STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, Board of Examiners of Nursing Home Administrators (BENHA) review, medical record review, observation, and interview, the facility failed to ensure a resident's right to be free from abuse neglect for 1 of 3 sampled residents (Resident #5) reviewed for wandering/elopement behaviors, when Resident #5 exited the COVID 19 isolation area, then exited the facility without staff awareness, walked down a sidewalk. Resident #5 traveled approximately 223 feet. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing (DON), and the Chief Clinical Officer (COO) were notified of the Immediate Jeopardy on 11/10/2033 at 3:44 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600. The facility was cited at F-600 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 10/30/2022 through 11/17/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/14/2022 at 12:44 PM, and was validated onsite by the surveyors on 11/16/2022 and 11/17/2022 through observations, review of audits, meeting minutes, and staff interviews. The findings include: 1. Review of the facility's undated policy titled, .Abuse Prevention, revealed, .Neglect: A failure of the facility, it's employees, or services provided .to provide goods and services necessary to avoid physical harm, mental anguish, emotional distress, or pain .Features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility .It is the responsibility of all staff to provide a safe environment for the residents. Resident care and treatments shall be monitored by all staff, on an ongoing basis, so that residents are free from abuse, neglect, or mistreatment . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's undated policy titled, MISSING RESIDENT/ELOPEMENTS, revealed .The Unit Charge Nurse is responsible for knowing the location of their residents .Missing Resident Guidelines . Determine time and location when last seen . Review of the facility's policy titled, Wandering, Unsafe Resident, revised 8/2014, revealed .The facility will strive to prevent unsafe wandering .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .A missing resident is considered a facility-wide emergency . 2. Review of the BENHA form revealed the Administrator had an employment date of 7/6/2020. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, Cognitive Social or Emotional Deficit following Cerebral Infarction. Review of a physician's order dated 8/16/2022, revealed Resident #5 had an order for a wander guard. Review of an elopement risk assessment dated [DATE] revealed Resident #5 was assessed at risk for elopement. Review of the Care Plan dated 8/16/2022, revealed Resident #5 was at risk for elopement related to poor safety awareness, was at risk for falls, had impaired cognitive function and was at risk for loneliness, anxiety and sadness related to isolation precautions related to COVID 19. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 was severely cognitively impaired for daily decision making and required one-person physical assistance with walking in his room or in the corridor. Review of a Progress Note dated 9/30/2022 at 4:30 PM, revealed .resident attempt to exit building .pursued resident and prevented him from exiting building . Review of a physician's order dated 10/28/2022 revealed Resident #5 had an order for contact isolation with droplet precautions related to a positive Covid diagnosis. Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .exit seeking x [times] 3 left COVID hall x 2 this am set off the alarm to door on 700 hall x 1 set off alarm on 500 hall door x 2 found in visitor parking lot per staff member . Review of a Progress Note dated 10/30/2022 at 11:33 AM revealed .staff alerted by 700 hall door alarm sounding off. Staff noted resident exiting 700 all [hall] door . Review of a Progress Note dated 10/31/2022 at 8:03 PM revealed .off COVID unit x 1 redirected to room . 30-minute checks continue .remains confused at baseline .remains on COVID unit with droplet precautions and contact isolation . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/8/2022 at 12:58 PM, CNA #1 stated, .yes, I was assigned to care for [Resident #5] on 10/30/2022 .he had got out of the unit a couple of times that day .I helped the nurse get him back in the COVID unit about 20 minutes after that I got a phone call from the [Activities Director] telling me he was outside . During an interview on 11/8/2022 at 1:28 PM, the Housekeeper stated, .I was in a resident room on the 800 hall .I didn't hear an alarm sounding .I looked out the window .saw the resident [Resident #5] walking outside on the sidewalk .I didn't see him walk out a door . During an interview on 11/9/22 at 11:10 AM, the Activity Director stated, .I saw him [Resident #5] walking down the sidewalk alone .I called [CNA #1] told her he was outside .I didn't see him walk out the door . During an interview on 11/10/2022 at 10:54 AM, the Administrator confirmed Resident #5 had exited the Covid Unit several times on 10/30/22. The Administrator further confirmed staff had not initiated every 30-minute checks until after the elopement. During a telephone interview on 11/10/2022 at 11:43 AM, LPN #1 stated, .yes, I was [Resident #5's] charge nurse on 10/30/2022, he got off of the Covid Unit several times. Two times he tried to get out on the 500 hall . I escorted him back to the Unit, then the 500 hall [exit] door alarm was sounding .he was trying to go out the door .took him back to the Covid Unit .then I found him at the [exit] door across from the DON office. I tried to get him back to the Unit, but he didn't want to go .so I had to get help from the CNA to get him back in the Covid Unit .I didn't see him go out the door .I didn't see him outside, I didn't see them bring him back in .I was told by staff he was outside . The facility staff assigned direct care for Resident #5 were aware he had exited the Covid Isolation Unit and had attempted to exit the facility several times during their shift. The direct care staff were unaware that he had exited the Covid Isolation Unit and was outside of the facility unsupervised. During a telephone interview on 11/14/2022 at 12:23 PM, Registered Nurse (RN) #1 stated, .I was told about the incident .it was secondhand information .someone alerted me that a resident was outside of the facility. We went outside to search, and when we came back, he was already back in the facility .there were no alarms sounding . During an interview on 12/2/2022 at 10:29 AM, the Administrator stated, .One (1) on 1 supervision would be warranted . Refer to F-609, F-610, F-689, F-725, F-726, F-880, F-835, F-867. The surveyors verified the Allegation of Compliance (AoC) Removal Plan through record review, observations, audit reviews, review of education and sign-in sheets, and interviews for the immediate corrective actions listed below: 1. The facility immediately called an ADHOC (formed for a special and immediate purpose)/Quality Assurance Performance Improvement (QAPI) meeting with department heads and QAPI team members at 4:00 PM on 11/10/2022. During the QAPI meeting a root cause analysis was completed pertaining to the resident that exited the COVID Unit and facility without staff knowledge (Resident #5). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Root cause identification included: Resident #5 who was moved to the Covid Unit, was trying to get out of the area. Resident #5 was looking to meet with his brother outside the building. He was a cognitively impaired resident who was moved to a new environment on the Covid Unit. The surveyors reviewed the QAPI meeting sign-in sheet, the minutes of the meeting and interviewed the DON and the Administrator. 2. New elopement assessment on Resident #5, who was identified as being outside without staff supervision was completed on 10/31/2022. The surveyors reviewed the elopement risk assessment. 3. A body audit was completed on 10/31/2022 on Resident #5, who was identified as being outside without staff supervision with no negative findings. The surveyors reviewed the body audit and interviewed the DON. 4. Resident #5, who was identified as being outside without staff supervision was placed on every 30-minute checks. The surveyors reviewed the every-30-minute check log and interviewed the Unit Manager. The every-30-minute checks were initiated at 11:15 AM on 10/30/2022. Every resident who was identified as at-risk for exit-seeking was placed on 30-minute checks on 11/11/2022 at 5:00 PM and continued. The surveyors reviewed the every-30-minute check sheets for residents identified as being at-risk for exit-seeking and interviewed staff. 5. The Care Plan was updated with new interventions for Resident #5, who was identified as being outside without staff supervision. New interventions included: Psychiatric evaluation and consultation. Face time with family member(s), and every 30-minute checks. The Care Plan was reviewed with the new interventions. The Psychiatric Nurse Practitioner was interviewed to verify the consultation was completed. The Psychiatric Nurse Practitioner progress note dated 11/10/2022 was reviewed by the surveyors. 6. Maintenance staff checked all exit doors and alarms for proper functioning on 10/30/2022. The surveyors reviewed the exit door check sheet and interviewed the Director of Maintenance about the process for checking the exit doors. The surveyors verified doors and alarms were functioning properly for the 700 hall door, the 800 hall door, and the 500 hall door. 7. Elopement drills were conducted on following dates with good response. 10/31/2022 at 3:21 PM for the 3-11 evening shift, 11/9/2022 at 11:20 AM for the 7-3 day shift, and 11/14/2022 at 6:18 AM for the 11-7 night shift. The surveyors observed the elopement drill on 11/9/2022 and reviewed the elopement drill sign sheet. 8. The facility conducted QAPI meetings on 10/31/2022 and 11/10/2022 regarding the 10-30-2022 incident on Resident #5, who was identified as being outside without staff supervision. The surveyors reviewed the QAPI minutes and interviewed the DON and the Administrator. 9. Resident #5, who was identified as being outside without supervision, was discharged from the COVID Unit on 11/9/2022 after completing quarantine time. The surveyors verified by observing Resident # 5 in a room on the 800 hall. 10. A psychiatric evaluation on Resident #5, who was identified as being identified outside without supervision, was completed on 11/10/2022. The surveyors interviewed the Psychiatric Nurse Practitioner related to the 11/10/2022 evaluation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. All residents that would like to participate in facetime and phone calls on the COVID Unit will be offered these services. Every resident who was currently in the Covid Unit was offered facetime/phone calls on 11/12/2022. Every resident will be offered facetime/phone calls with family members at least weekly and as needed. The Social Worker/Activities staff will visit the resident with an iPad or cell phone and coordinate calls. The surveyors verified through interview with the Social Services Director and review of the form used to ensure residents were offered facetime/phone calls with family members. 12. The facility will ensure sufficient staff and supervision on the COVID Unit for all residents. Staffing needs will be determined based on the census and acuity in the Covid Unit. The goal will be to have at least one nurse for the Unit and one CNA for every 10 residents. The surveyors verified through interview with the Staffing Coordinator, Interim DON, and the Administrator. The surveyors reviewed the updated Covid Unit staffing policy. 13. The facility immediately started in-services and education on neglect and accidents on 10/31/2022 and is ongoing. All facility employees are required to attend in-services/education regarding neglect and accidents. In-service education started 10/30/2022 and will be continued to attain over 100% compliance by 11/15/2022. Employees who are on vacation, family medical leave or as needed (prn) staff will be required to complete the training prior to return to work. The surveyors reviewed the in-service education literature, reviewed the sign in sheets and interviewed staff on all shifts to verify. 14. The facility will audit all exit-seeking/elopement risk residents every shift by conducting every-30-minute checks. The findings will be reviewed in the daily morning meetings. The Charge Nurse/designee will conduct audits for exit-seeking/elopement risk residents. The surveyors interviewed the Charge Nurse and reviewed the audit tool. The facility's noncompliance of F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, medical record review, and interview, the facility failed to report incidents of elopement for 1 of 3 sampled residents (Resident #5) reviewed for wandering and elopement. The facility's failure to report an incident of elopement and neglect to the State Survey Agency resulted in Immediate Jeopardy when Resident #5 exited the facility on 10/30/2022 without staff knowledge or supervision. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 11/16/2022 at 5:19 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-609. The facility was cited at F-609 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 10/30/2022 through 11/22/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/18/2022 at 10:13 AM, and was validated onsite by the surveyors on 11/21/2021 and 11/22/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the facility's undated policy titled, .ABUSE PREVENTION, revealed .Alleged violations involving abuse, neglect, exploitation or mistreatment, including injury of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .to other officials .including State Survey Agency .Report the results of all investigations to the administrator or designated representative and other officials in accordance with state law including State Survey Agency within 5 working days of the incident . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, Cognitive Social or Emotional Deficit following Cerebral Infarction. Review of an elopement risk assessment dated [DATE] revealed Resident #5 was assessed at risk for elopement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician's order dated 8/16/2022, revealed Resident #5 had an order for a wander guard. Review of the Care Plan dated 8/16/2022, revealed Resident #5 was at risk for elopement related to poor safety awareness, was at risk for falls, had impaired cognitive function, and was at risk for loneliness, anxiety and sadness related to isolation precautions related to COVID 19. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 was severely cognitively impaired for daily decision making and required one-person physical assistance with walking in his room or in the corridor. Review of a Progress Note dated 9/30/2022 at 4:30 PM, revealed .resident attempt to exit building .pursued resident and prevented him from exiting building . Review of a physician's order dated 10/28/2022 revealed Resident #5 had an order for contact isolation with droplet precautions related to a Covid-positive diagnosis. Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .exit seeking x [times] 3 left COVID hall x 2 this am set off the alarm to door on 700 hall x 1 set off alarm on 500 hall door x 2 found in visitor parking lot per staff member . Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .staff alerted by 700 hall door alarm sounding off. Staff noted resident exiting 700 all [hall] door . During an interview on 11/3/2022 at 11:18 AM, the DON stated, .Sunday [10/30/2022] a resident [Resident #5] left the building, I was notified by the RN [Registered Nurse] supervisor. She said eyes were on him the entire time .Had a QAPI [Quality Assurance Performance Improvement] meeting on Monday [10/31/2022], Activity Director was in the meeting and said nothing when we discussed the incident .determined since staff had eyes on him, it was not reportable at that time . During an interview on 11/3/2022 at 11:25 AM, the Administrator stated, .the incident has not been reported . I notified the COO [Chief Operations Officer] and agreed not reportable since staff had eyes on him . During an interview on 11/8/2022 at 12:58 PM, Certified Nursing Assistant (CNA) #1 stated, .I did not know he was outside of the facility until [Activities Director] called and told me he was outside . During an interview on 11/8/2022 at 1:28 PM, the Housekeeper stated, .I was in a resident room on the 800 hall .saw the resident [Resident #5] walking outside on the sidewalk toward the parking lot .he was by himself . During an interview on 11/9/2022 at 11:10 AM, the Activity Director stated, .I saw him [Resident #5] walking down the sidewalk alone .I called [CNA #1] told her he was outside .I didn't see him walk out the door . The facility was unable to provide evidence that staff saw Resident #5 exit the building on 10/30/2022. He was found outside the facility alone and unsupervised. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/9/2022 at 12:28 PM, the Chief Clinical Officer (CCO) stated, .my understanding was the incident was reported on Wednesday [11/2/2022] . During an interview on 12/2/2022 at 11:53 AM, the Administrator stated .this incident should have been reported earlier . Refer to F-600, F-610, F-689, F-725, F-726, F-880, F-835, F-867. The surveyors verified the Allegation of Compliance (AoC) Removal Plan through record review, observations, audit reviews, review of education and sign-in sheets, and interviews for the immediate corrective actions listed below: 1. The facility conducted ADHOC (formed for a special and immediate purpose)/Quality Assurance Performance Improvement (QAPI) meeting with the management team on 11/16/2022 at 6:00 PM, and completed a root cause analysis. Root cause identification included late reporting and failure to conduct a thorough investigation. The facility received conflicting statements from different employees, which caused a delay in collecting statements and information from employees. The surveyors reviewed the QAPI meeting minutes and sign-in sheet and interviewed the Administrator and the DON. 2. The facility reported the incident to the Tennessee Department of Health on 11/3/2022 regarding the cognitively impaired resident (Resident #5) that was identified as being found outside unsupervised. The surveyors reviewed the Incident Reporting System information sheet and interviewed the DON. 3. The Administrator/DON will review all incidents and accidents for the last 30 days to ensure that any incident that was considered a reportable event by the state and federal regulations was reported appropriately. The surveyors reviewed the audit form and interviewed the Administrator and DON. 4. All incidents will be reported timely to all appropriate agencies within 24 hours of occurrence regarding any incident that could result in harm or death. The Administrator or the DON/designee will be responsible for reporting to all appropriate agencies. Designee by title includes ADON, In-service Coordinator, Unit Managers and Weekend Supervisor. The Weekend Supervisor will be trained in incident investigation and reporting over the weekends by the In-service Coordinator by 11/18/2022. Incident reporting system (IRS) reporting required over the weekends will be completed with assistance from the Administrator, DON or ADON. The ADON, In-service Coordinator and Unit Managers have been assigned days as Manager on Duty (MOD) including holidays to be responsible for thorough investigation and reporting events timely. The surveyors interviewed the Administrator and DON regarding proper reporting timeframes. The surveyors reviewed the Manager on Duty form and interviewed staff responsible for investigation and reporting. 5. The Administrator and DON were trained by the Consultant regarding thorough investigation and reporting to the appropriate agencies timely. The Administrator and DON are responsible for timely reporting in addition to the responsibilities of the Designees. The surveyors interviewed the Administrator and DON regarding investigation and timely reporting of incidents. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The facility will ensure that all incidents with major injury will be reported within 2 hours and all other reportable events within 24 hours. The surveyors interviewed the Administrator, the DON and the Unit Managers regarding reporting of incidents. In addition to the Administrator and DON, additional members of the nursing management team including the ADON, the In-service Coordinator, and Unit Managers were also trained on incident investigation and reporting. This training included reporting requirements within two hours and within 24 hours. The Weekend Supervisor will be trained in incident investigation and reporting over the weekends by the In-service Coordinator by 11/18/2022. The surveyors interviewed the ADON and Unit Managers regarding investigation and reporting. The facility added additional users to the incident reporting system (IRS allows maximum 4 users) with the capability for remote accessing and reporting as needed. Additional training on thorough investigation and reporting will be provided to the Administrator, DON, and additional members of the nursing management team including the ADON, In-service Coordinator, and Unit Managers. The surveyors verified through interview with the Administrator, the DON, and the Unit Managers. 7. The Administrator/DON/ADON will be contacted via phone by Nursing Supervisor/Charge Nurse if any incident that required IRS reporting for guidance. The surveyors interviewed Charge Nurses on all shifts. This was verified by interview with the DON and Administrator and review of a facility reported incident that occurred on 11/20/2022. 8. The Administrator/Designee will audit all reportable events daily during morning meetings and report findings to the QAPI committee. Designee by title includes ADON, In-service Coordinator, Unit Manager and Weekend Supervisor. Unit Managers will bring incident information daily to the morning meetings for review by the Administrator. In the absence of the Administrator, the DON will be responsible for reviewing incidents in the morning meetings. If both are unavailable, the chain of command will be the ADON, the In-service Coordinator, Unit Managers and Weekend Supervisor. Responsibilities are assigned specifically. The surveyors interviewed the DON, the ADON, and Unit Managers and reviewed in-service sign in sheets. This was verified by interview, review of a reported incident, review of in-service sheets and interview with facility and agency staff on all shifts. The facility's noncompliance of F-609 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, medical record review, observation and interview the facility failed to thoroughly investigate an incident of elopement for 1 of 3 sampled residents (Resident #5) reviewed for elopement and wandering. The facility's failure to thoroughly investigate an incident of elopement resulted in Immediate Jeopardy when Resident #5 eloped from the Covid Unit, exited the facility, and walked unsupervised down a sidewalk toward a parking area. The vulnerable, confused resident ambulated approximately 223 feet from the facility unsupervised. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy on 11/16/2022 at 5:19 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-610. The facility was cited Immediate Jeopardy at F-610 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 10/30/2022 through 11/22/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/18/2022 at 10:13 AM, and was validated onsite by the surveyors on 11/21/2021 and 11/22/2021 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the facility's policy titled, INCIDENT REPORT-DOCUMENTATION, INVESTIGATING, AND REPORTING, revised 9/20/2021, revealed, .all accidents or incidents involving residents .shall be investigated and reported to the administrator . Review of the facility's undated policy titled, Accident & Incident Documentation & Investigation Resident Incident, revealed .The Licensed Nurse assigned at the time of the resident care accident/incident is responsible for conducting an investigation of the circumstances surrounding the accident/incident, and for notifying the Supervisor, Director of Nursing, and/or the Executive Director .The Licensed Nurse .is responsible for initiating/completing the Resident Incident Report, ensuring that all items identified on the form have been completed as applicable to the accident/incident. Review of the facility's undated policy titled, Abuse Prevention, revealed, .The Executive Director and Director of Nursing Services must be promptly notified of suspected abuse or incidents of abuse .if such incidents occur or are discovered after hours, the Executive Director and Director of Nursing Services must be called .and informed of such incident .The facility will initiate at the time of any finding of potential abuse or neglect an investigation to determine cause and effect, and provide protection to any alleged victims to prevent harm during the continuance of the investigation . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, Cognitive Social or Emotional Deficit following Cerebral Infarction. Review of a physician's order dated 8/16/2022, revealed Resident #5 had an order for a wander guard. Review of the Care Plan dated 8/16/2022, revealed Resident #5 was at risk for elopement related to poor safety awareness, at risk for falls, impaired cognitive function and at risk for loneliness, anxiety and sadness related to isolation precautions related to COVID 19. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 had severely impaired cognition for daily decision making and required one-person physical assistance with walking in his room or in the corridor. Review of a Progress Note dated 9/30/2022 at 4:30 PM, revealed .resident attempt to exit building .pursued resident and prevented him from exiting building . Review of a physician' order dated 10/28/2022 revealed Resident #5 had an order for contact isolation with droplet precautions related to a Covid positive diagnosis. Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .exit seeking x 3 left COVID hall x 2 this am set off the alarm to door on 700 hall x 1 set off alarm on 500 hall door x 2 found in visitor parking lot per staff member . Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .staff alerted by 700 hall door alarm sounding off. Staff noted resident exiting 700 all [hall] door . Review of a Progress Note dated 10/31/2022 at 8:03 PM, revealed .off COVID unit x 1 redirected to room . 30-minute checks continue .remains confused at baseline .remains on COVID unit with droplet precautions and contact isolation . During an interview on 11/3/2022 at 11:18 AM, the DON and the Administrator confirmed the camera footage had not been reviewed to determine where Resident #5 went out of the facility or what time he was last captured on video in the facility. During an interview on 11/7/2022 at 1:40 PM, the Administrator stated, .we have talked to all of the staff .he was seen by staff outside .eyes on him the whole time he was outside .I have the typed-up account of the reenactment done with the Housekeeper. That is all I have related to the investigation involving [Resident #5] . During an interview on 11/8/2022 at 4:36 PM, the DON confirmed she had not directed the Registered Nurse (RN) supervisor to obtain statements from the facility staff or to complete an incident report. During an interview on 11/7/2022 at 4:50 PM, the Administrator stated, .I did find some pictures on my phone of the incident .not able to save a video of the incident .just able to see still pictures of the camera footage . did not review them until today . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/8/2022 the Administrator provided screenshots of Resident #5 inside the facility and outside of the facility. The Administrator confirmed there were no staff outside with Resident #5. During an interview on 11/9/2022 at 11:00 AM, the Administrator stated, .the investigation of the incident is ongoing. We are not finished .the Staffing Coordinator worked that day . During an interview on 11/9/2022 at 11:10 AM, the Staffing Coordinator stated, .I worked that day. I turned the alarm off to the 800 hall exit door .I did not write a statement until today, because they [Administrator and DON] did not know I worked . On 11/9/2022 the Administrator provided still photos of the camera footage. The Administrator stated, We're not able to get a copy of the video, only still photos of the video . The Administrator was not able to provide the photos on a storage device. The Administrator stated, .I'm not able to extract the pictures . During an interview on 11/10/2022 at 10:15 AM, the Administrator confirmed there was no staff outside with the resident. Refer to F-600, F-609, F-689, F-725, F-726, F-835, F-867 and F-880. The surveyors verified the Removal Plan by: 1. The facility conducted ADHOC (formed for a special and immediate purpose)/Quality Assurance Performance Improvement (QAPI) with the management team on 11/16/2022 at 6:00 PM, and completed a root cause analysis. Root cause identification included: Late reporting and not conducting a thorough investigation. The facility received conflicting statements from different employees, creating a delay in collecting statements and information from employees. The surveyors reviewed the QAPI meeting minutes and sign-in sheet, and interviewed the Administrator and the DON. 2. The facility reported the elopement incident to the Tennessee Department of Health on 11/3/2022 regarding the cognitively impaired resident (Resident #5) that was identified as being found outside unsupervised. The surveyors reviewed the Incident Reporting System information sheet and interviewed the DON. 3. The Administrator/DON will review all incidents and accidents for the last 30 days to ensure that any incident that was considered a reportable event by the state and federal regulations was reported appropriately. The surveyors reviewed the audit form and interviewed the Administrator and DON. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. All incidents will be reported timely to all appropriate agencies within 24 hours of occurrence regarding any incident that could result in harm or death. The Administrator or the DON/designee will be responsible for reporting to all appropriate agencies. Designee by title includes ADON, In-service Coordinator, Unit Managers and Weekend Supervisor. The Weekend Supervisor will be trained in incident investigation and reporting over the weekends by the In-service Coordinator by 11/18/2022. Incident reporting system (IRS) reporting required over the weekends will be completed with assistance from the Administrator, DON or ADON. The surveyors interviewed the Administrator and DON regarding proper reporting timeframes. The surveyors reviewed the Manager on Duty form and interviewed staff responsible for investigation and reporting. Additional training on thorough investigation was provided to the Administrator, DON and additional members of the nursing management team including the ADON, In-service Coordinator and Unit Managers. The ADON, In-service Coordinator and Unit Managers have been assigned days as Manager on Duty (MOD) including holidays to be responsible for thorough investigation and reporting events timely. The surveyors reviewed the Manager on Duty roster and interviewed staff regarding their responsibility when on call. Staff were interviewed related to thorough investigations and reporting of events timely. 5. All missing statements were collected as part of the ongoing investigation by 11/3/2022 concerning Resident #5, who was identified as having exited the facility without staff knowledge. Resident #5 was placed on a every 30-minute checks. A psychiatric evaluation was completed. The Care Plan was updated with new interventions. In-service education to prevent neglect and accidents was completed for all staff members. Record review and observation were included as part of the investigation. The surveyors reviewed the investigation on 11/3/2022 and 12/1/2022. 6. The facility will ensure that all incidents with major injury will be reported within 2 hours and all other reportable events within 24 hours. The surveyors interviewed staff regarding reporting guidelines. In addition to the Administrator and DON, additional members of the nursing management team including the ADON, the In-service Coordinator, and Unit Managers were also trained on incident investigation and reporting. This training included reporting requirements within 2 hours and within 24 hours. The Weekend Supervisor will be trained on incident investigation and reporting over the weekends by the In-service Coordinator by 11/18/2022. The surveyors interviewed the Administrator, the DON, and Unit Managers regarding investigation and reporting. The surveyors reviewed a facility reported incident that occurred on 11/20/2022. The facility added additional users to the Incident Reporting System (IRS allows maximum 4 users) with the capability for remote accessing and reporting as needed. Additional training on thorough investigation and reporting will be provided to the Administrator, DON, and additional members of the nursing management team including the ADON, the In-service Coordinator, and Unit Managers. The surveyors interviewed the Administrator, the DON, the Unit Managers, and the ADON. 7. The Consultant will educate the Administrator and DON regarding proper reporting and thorough investigating which include collecting witness statements timely. The surveyors interviewed the Administrator and DON regarding proper reporting and thorough investigation of incidents. 8. The Administrator/DON/ADON will be contacted via phone by the Nursing Supervisor/Charge Nurse if any incident that required IRS reporting for guidance. The surveyors interviewed Charge Nurses from all shifts, the Administrator, the DON and the ADON regarding reporting. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. The Administrator/Designee will audit all reportable events daily during morning meetings and report findings to the QAPI committee. Designee by title includes the ADON, the In-service Coordinator, Unit Managers and Weekend Supervisors. Unit managers will bring incident information daily to the morning meetings for review by the Administrator. In the absence of the Administrator, the DON will be responsible for reviewing incidents in the morning meetings. If both are unavailable, the chain of command will be the ADON, the In-service Coordinator, Unit Managers and Weekend Supervisors. Responsibilities are assigned specifically. The surveyors interviewed the Administrator, the DON, the ADON and Unit Managers regarding reportable events audits during morning meetings. The facility's noncompliance of F-610 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, medical record review, observation and interview the facility failed to ensure a safe environment to prevent an incident of elopement for 1 of 3 (Resident #5) sampled residents reviewed for elopement and wandering behaviors, which resulted in Immediate Jeopardy (IJ) when a cognitively impaired resident exited the facility without authorization or staff supervision. The facility was unaware the resident had exited the facility until a housekeeper looked out a window and saw the resident walking on the sidewalk outside of the facility toward the parking area. The facility failed to ensure fall risk assessments were completed for 2 of 3 sampled residents (Resident #9 and Resident #2) reviewed for falls. The failure of the facility to implement measurable interventions resulted in actual harm when Resident #9 had a fall with a major injury. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing, and the Chief Clinical Officer were notified of the Immediate Jeopardy on 11/10/2022 at 3:44 PM, in the conference room of the facility. The facility was cited Immediate Jeopardy at F-689. The facility was cited F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ existed 10/30/2022 through 11/18/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/14/2022 and was validated onsite by the surveyors on 11/17/2022 through 11/18/2022 by policy review, medical record review, observation, review of education records, auditing tools, and staff and resident interviews. The findings include: 1. Review of the facility's undated policy titled, MISSING RESIDENT/ELOPEMENTS, revealed, .The Unit Charge Nurse is responsible for knowing the location of their residents .Missing Resident Guidelines . Determine time and location when last seen . Review of the facility's policy titled, Wandering, Unsafe Resident, Revised 8/2014, revealed, .The facility will strive to prevent unsafe wandering .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .A missing resident is considered a facility-wide emergency .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Contact the Attending Physician and report findings and conditions of the resident . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, Fall Risk Assessment, revised March 2018, revealed, .The nursing staff . will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information .Upon admission, the nursing staff and physician will review a resident's record for a history of falls .nursing staff will ask the resident and his/her family about any history of the resident falling .staff and attending physician will .identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable . 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, Cognitive Social or Emotional Deficit following Cerebral Infarction. Review of the Care Plan dated 8/16/2022, revealed Resident #5 was care planned at risk for elopement related to poor safety awareness related to his admission diagnosis of WERNICKE'S ENCEPHALOPATHY (a degenerative brain disorder). The goal was for Resident #5 to remain safely on facility property until a safe discharge was possible. Interventions included assess/observe patterns of exit-seeking behavior and remove/eliminate triggers when possible, check wander guard placement every shift, consult psychiatric and/or psychology services as ordered by physician, encourage participation and interactions that decrease anxiety and exit seeking, place resident's picture in elopement binders throughout the facility and notify receptionist/security staff, redirect resident away from exits as needed, a wander guard to be placed for resident safety, and avoid leaving Resident #5 unattended or unobserved for long periods of time. Review of an elopement risk assessment dated [DATE], revealed Resident #5 had a score of 2, which indicated he was at risk for elopement. Review of a physician's order dated 8/16/2022, revealed Resident #5 had an order for a wander guard. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 had severely impaired cognition for daily decision making and required one-person physical assistance with walking in his room or in the corridor. Review of a physician's order dated 10/28/2022, revealed Resident #5 had an order for contact isolation with droplet precautions related to a positive Covid diagnosis. Review of a Progress Note dated 9/30/2022 at 4:30 PM, revealed, .resident attempt to exit building .pursued resident and prevented him from exiting building . Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed, .exit seeking x [times] 3 left COVID hall x 2 this am [morning] set off the alarm to door on 700 hall x 1 .set off alarm on 500 hall door x 2 .found in visitor parking lot per staff member . Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed, .staff alerted by 700 hall door alarm sounding off. Staff noted resident exiting 700 all [hall] door . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The cognitively impaired resident (Resident #5) exited the Covid Unit several times prior to exiting the facility (elopement) unsupervised on 10/30/2022. The facility failed to implement interventions that prevented the resident from exiting the facility. Review of a Progress Note dated 10/31/2022 at 8:03 PM, revealed, .off COVID unit x 1 redirected to room . 30-minute checks continue .remains confused at baseline .remains on COVID unit with droplet precautions and contact isolation . Observation of the area outside of the 700 hall exit door on 11/8/2022 beginning at 1:45 PM, with the Maintenance Director and the Speech Therapist, revealed a concrete sidewalk around the building, which was noted with several areas of a 3 1/2 inch descent to the ground. There was a 3-foot 3 inch ditch running parallel to the sidewalk, and the sidewalk was covered in small round nuts which caused an uneven walking surface. It was approximately 274 feet from the 700 hall exit door to the sidewalk where Resident #5 was seen by the housekeeping staff. There was a sidewalk from the 800 hall exit door to the parking lot. The parking lot was located approximately 223 feet from where the resident was seen by the housekeeping staff, as measured by the Speech Therapist. During a telephone interview on 12/2/2022 at 9:25 AM, the physician stated, .not safe for [Resident #5] to be outside unsupervised .I was not aware of any attempts before this incident . 3. Medical record reviewed revealed Resident #9 was admitted on [DATE], with diagnoses of Cerebral Infarction, Anemia, History of Falling, Metabolic Encephalopathy, Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of the admission fall risk assessment dated [DATE], revealed the assessment was incomplete. Review of the admission assessment dated [DATE], revealed the assessment was not signed until 11/15/2022. Review of the baseline care plan dated 11/4/2022, revealed Resident #9 is at risk for falls related to the new and unfamiliar environment, poor safety awareness, and unsteady gait with weakness. The interventions included anticipate and meet resident's needs as needed and keep the room free of clutter and obstacles that may pose trip hazards. Review of the admission MDS dated [DATE], revealed Resident #9 was assessed by staff as having severe cognitive impairment for decision making, had trouble concentrating, exhibited behaviors including rejection of care and wandering, required one-person limited assistance with activities of daily living, and had a history of falls prior to admission. Review of the Incident Details Report dated 11/10/2022, revealed, .CNA [Certified Nursing Assistant] called for the nurse to come to the resident's room. Resident was found on the floor .resident has right side head injury with a raised area over the eye .hematoma forehead . Resident #9's admission assessment and fall risk assessment was not completed. The baseline care plan did not include person centered measurable interventions to prevent falls. Resident #9 fell on [DATE] and sustained a hematoma to the right side of her face. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/17/2022 at 11:31 AM, the Interim DON stated, .the admission assessment should be completed within 24 hours of admission .fall risk assessments are completed upon admission and when a fall occurs The Interim DON confirmed Resident #9's admission assessment was not completed within 24 hours of admission and the admission fall risk assessment was not completed. 4. Review of a closed medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses of Anemia, Cerebral Infarction, and Esophagitis. Review of the fall risk assessment dated [DATE], revealed Resident #2 was assessed at moderate risk for falls. Review of the admission MDS dated [DATE], revealed Resident #2 was assessed with a BIMS of 11 indicating moderate cognitive impairment for decision making. Resident #2 required assistance with activities of daily living. Review of the Care Plan revised 10/21/2022, revealed fall interventions to anticipate and meet resident's needs, and physical therapy to evaluate and treat as ordered and as needed. Review of the Incidents by Incident Type report dated 8/1/2022 through 12/2/2022, revealed Resident #2 was not listed as having a fall on 10/25/2022. During an interview on 11/16/2022 at 10:54 AM, the DON confirmed Resident #2 had a fall on 10/25/2022. The DON stated, The CNA did not report the fall to the charge nurse .I received the information on 10/26/2022 .in-serviced staff .talked to them about reporting falls .didn't have them sign anything .a fall investigation was completed the next day .a fall risk assessment was not completed after the fall . There were no noted injuries to Resident #2. During a telephone interview on 11/23/2022 at 10:37 AM, CNA #3 stated, .yes [Resident #2] was in the floor I helped [CNA #4 and #5] get her up into the wheelchair .no I did not report it to the nurse . Review of personnel files for CNA #3, CNA #4, and CNA #5 on 11/15/2022, revealed there were no disciplinary actions or education provided related to reporting falls. During an interview on 11/16/2022 at 11:05 AM, the DON confirmed the fall investigation was not signed by the staff completing the investigation. During a telephone interview on 11/21/2022 at 3:40 PM, the Chief Operations Officer stated, .fall investigation should be signed .fall risk assessments should be completed after a fall and on admission .if staff observe a fall and do not report it to the nurse, the staff are educated and disciplined .should be in their personnel record . The surveyors verified the Allegation of Compliance (AoC) Removal Plan through record review, observations, audit reviews, review of education and sign-in sheets, and interviews for the immediate corrective actions listed below: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility immediately called ADHOC (formed for a special and immediate purpose)/Quality Assurance Performance Improvement (QAPI) meeting with department heads and QAPI team members at 4:00 PM on 11-10-2022. During the QAPI meeting a root cause analysis was completed pertaining to Resident #5 that exited the COVID-19 Unit and facility without staff knowledge. Root cause identification included: Resident who was moved in to the Covid Unit, was trying to get out of the area. The resident was looking to meet with his brother outside the building. He was a cognitively impaired resident and moved to a new environment on the Covid Unit. The surveyors reviewed the QAPI meeting minutes and interviewed the Administrator and the DON. 2. A new elopement assessment on Resident #5 that was identified as being outside without staff supervision was completed on 10-31-2022. The surveyors reviewed the elopement risk assessment. 3. A body audit was completed 10-31-2022 on Resident #5 that was identified as being outside without staff supervision with no negative findings. The surveyors reviewed the body audit and interviewed the DON. 4. The resident that was identified as being outside without staff supervision (Resident #5) was placed on every 30-minute checks. Every 30-minute checks were initiated at 11:15 AM on 10/30/2022. The every-30-minute check sheet was reviewed, and staff was interviewed about the every-30-minute checks. Every resident who was identified as at risk for exit-seeking was placed on 30-minute checks on 11/11/2022 at 5:00 PM, and continued. The surveyors reviewed the 30-minute check sheets for all residents and observed checks being completed. The surveyors interviewed direct care staff regarding the 30-minute checks. 5. The Care Plan was updated with new interventions in place for Resident #5 that was identified as being outside without staff supervision. New interventions included: Psychiatric evaluation and consultation, face time with family member (s) every 30-minute check. The surveyors interviewed the Psychiatric Nurse Practitioner and reviewed the Social Services note regarding the phone call with family member. 6. Maintenance staff checked all exit doors and alarms for proper functioning on 10-30-2022. The surveyors reviewed the exit door checks and interviewed the Maintenance Director. 7. Elopement drills were conducted on following dates with good response: 10/31/2022 at 3:21 PM for the 3-11 evening shift; 11/9/2022 at 11:20 AM for the 7-3 day shift; and 11/14/2022 at 6:18 AM for the 11-7 night shift. The surveyors observed the elopement drill on 11/9/2022 day shift and reviewed the sign in sheet. 8. The facility conducted a QAPI meeting regarding the 10-30-2022 incident on the resident identified as being outside without staff supervision. The surveyors reviewed the QAPI meeting form, the sign-in sheet, and interviewed the Administrator and Director of Nursing. 9. The resident identified as being outside without supervision (Resident #5) was discharged from the COVID-19 Unit on 11-9-2022 after completing quarantine time. The surveyors confirmed the resident was no longer residing in the COVID-19 unit. (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. A psychiatric evaluation was completed on 11-10-2022 on the resident identified as being outside without supervision (Resident #5). The surveyors interviewed the Psychiatric Nurse Practitioner and reviewed the progress note from the 11-10-2022 visit. 11. All residents that would like to participate in facetime and phone calls on the COVID-19 Unit will be offered. Every resident currently in the Covid Unit were offered facetime/phone calls on 11/12/2022. Every resident will be offered facetime/phone calls with family members at least weekly and as needed. Social Worker/Activities staff will visit the residents with an iPad or cell phone and coordinate calls. The surveyors reviewed the log sheet of residents offered and those that participated in a facetime/phone call. The surveyors interviewed the Social Worker and Activities Director regarding facetime/phone calls for residents on the Covid Unit. 12. The facility will ensure sufficient staff and supervision on the COVID-19 Unit for all residents. Staffing needs will be determined based on the census and acuity in the Covid Unit. The goal will be to have at least 1 nurse for the COVID Unit and 1 CNA for every 10 residents. The surveyors interviewed the Staffing Coordinator, Administrator and the Interim Administrator regarding Covid Unit staffing. 13. The facility immediately started in-services and education on neglect and accidents on 10-31-2022 and is ongoing. All facility employees are required to attend in-services/education regarding neglect and accidents. In-service education started 10/30/2022 and will be continued to attain over 100% compliance by 11/15/2022. Employees who are on vacation, family medical leave, or are scheduled as-needed will be required to complete the training prior to return to work. The surveyors reviewed the education, reviewed the sign-in sheets, and interviewed staff on all shifts. 14. The facility will audit all exit-seeking/elopement risk residents every shift by conducting every-30-minute checks. Findings will be reviewed in the daily morning meetings. Charge Nurse/designee will conduct audits for exit-seeking/elopement risk residents. The surveyors reviewed the audit form and interviewed Administration and facility staff regarding audits and morning meetings. The facility's noncompliance of F-689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 31839 Based on job description review, facility staffing schedules, daily staffing sheet, punched detailed report review, agency time detailed report review, and interview, the facility failed to provide sufficient nursing staff to ensure supervision of residents. The facility's failure to ensure sufficient staffing for adequate resident supervision resulted in Immediate Jeopardy for 1 of 5 sampled residents (Resident #5) when a vulnerable resident with severe cognition impairment with wandering and elopement behaviors, and a positive COVID diagnosis, exited the COVID Unit 3 different times, and then exited the facility and was found by staff in the parking lot unsupervised and without Personal Protective Equipment (PPE) in place. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing (DON), and the Chief Operating Officer (COO) were notified of the Immediate Jeopardy on 11/21/2033 at 4:41 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-725. The facility was cited at F-725 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was existed from 10/30/2022 through 12/2/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/18/2022 at 10:13 PM, and was validated onsite by the surveyors on 11/30/2022 through 12/1/2022 through observations, review of audits, meeting minutes, and staff interviews. The findings include: 1. Review of the Administrator Job Description, signed by the Administrator on 7/6/2020, revealed, .The primary purpose of your position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all time .Personnel Functions .Ensure that an adequate number of appropriately trained licensed professional and non-professional personnel are on duty at all times to meet the needs of the residents. Ensure that appropriate staffing level information is posted on a daily basis. Review and check competence of work force and make necessary adjustments or corrections as required or that may become necessary . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Director of Nursing Services Job Description dated 3/16/2020, revealed, .The primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator or the Medical Director to ensure that the highest degree of quality care is maintained at all times .Administrative Function .Assist in calculating the number of direct nursing care personnel on duty each shift. Report such information to the Administrator or his/her designee to ensure that accurate staffing information is posted .Personnel Functions Inform the Nurse Supervisor and/or Unit Manager of staffing needs when assigned personnel fail to report to work . Determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents. Supervise and assist scheduling of employees within established state guidelines .Assign a sufficient number of LPN's [Licensed Practical Nurse] and RNs [Registered Nurse] for each tour of duty to ensure that quality care is maintained. Assign a sufficient number of CNAs/GNAs [Geriatric Nurse Aide] as applicable for each tour of duty to ensure that routine nursing care is provided to meet the daily nursing care needs of each resident .Nursing Care Functions .Provide the Administrator with information relative to the nursing needs of the resident and the nursing service department's ability to meet those needs . 2. Review of the Midnight Census Report and Daily Schedule dated 10/30/2022 revealed a total census of 148 residents. A total of 49 residents resided on the 100 and 200 Halls. A total of 49 residents resided on the 300 and 400 Halls, and a total of 30 residents resided on the 500 and 600 Halls (11 residents resided on the COVID Unit, rooms 606-617). A total of 20 residents resided on the 800 Hall. Daily Schedule revealed on the day shift (6:45 AM-3:15 PM) on 10/30/2022, 6 Licensed Practical Nurses (LPNs) were scheduled. 3. Review of the Daily Assignment Sheets dated 10/30/2022, revealed day shift (6:45 AM-3:15 PM) assignments showed 1 Certified Nursing Assistant (CAN) for rooms 500-504 and 600-605; 1 CNA for rooms 505-512 and 811w (window)-817; 1 CNA for (COVID Unit) rooms 606-617; and 1 CNA for rooms 800-811d (door). 4. Review of the Daily Staffing Sheet, Punched Detailed Report, Agency Time Detailed Report dated 10/30/2022, revealed 0700 days 8 CNAs with 1 CNA clocking punch time at 10:05 AM and 1 CNA clocking punched out time at 12:58 PM. 5. During an interview on 11/8/2022 at 4:36 PM, the Administrator stated, .during the QAPI (Quality Assurance Performance Improvement) [meeting] on 10/21[2022], we had a meeting regarding the COVID outbreak .we would have designated staffing in the Covid Unit: 1 nurse, 1 CNA, and 1 housekeeper .the day of the elopement [10/30/22], there should have been designated staff in the COVID Unit .staff had to work outside the Covid Unit picking up other residents .if someone called in, that staff had to cover .there was [were] 11 residents on the COVID Unit that day . The Administrator confirmed that the nurse and CNA had other residents assigned outside of the Covid Unit, and were not designated only to the COVID Unit stating, . we shot ourselves in the foot when we put that in place .with the staffing challenges .the DON should provide the oversight for the staffing, but that wasn't done . During an interview on 11/8/2022 at 1:01 PM, CNA #1 stated, .I was assigned the COVID Unit and provided care to residents assigned outside of the COVID Unit on another hall .it was hard for me to keep eyes on him [Resident #5] .he was up wandering around and going out of the COVID Unit .I brought him back in the unit several times .then I got a call he was out in the parking lot .there was no way I could have watched him closely, because I had other residents outside the COVID Unit . (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Unit Managers will monitor and audit every-30-minute checks daily on all exit seeking residents. Findings will be reviewed and reported in the morning meetings daily. Resident added to the wander list since audit started. This was validated by surveyors through review of 30-minute check sheets of all wandering and exit-seeking residents and review of audits and interviews with Unit Managers. 3. All facility staff were educated on incidents/accidents and supervision. This was validated by surveyors through interviews with agency and facility staff conducted on all shifts, and sign-in sheets were reviewed for all staff and agency staff. 4. Administrator/DON/ADON will monitor staffing each morning in the morning meetings to ensure adequate staffing is provided for the COVID Unit specifically and for the facility in general. This was validated by surveyors through review of the COVID Unit census with staffing assignment sheets and observations. 5. Administrator/DON/ADON will review staffing for the following day with the Staffing Coordinator on the previous day before posting to ensure adequate staff members are scheduled daily. This was validated by surveyors through review of daily staff postings and schedules. 6. Administrator/DON and Staffing Coordinator will review daily PPD and take action to replace call outs, including use of agency staff, as-needed (PRN) staff, and management staff to ensure adequate staffing is available for the COVID Unit specifically, and the facility in general, each day in the morning meetings. This was validated by surveyors through review of staff postings and schedules, and interviews. The facility's noncompliance of F-725 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, job description review, staff personnel file review, medical record review, observation, and interview, the facility failed to ensure nursing staff were competent and proficient in practices to maintain residents' highest practical well-being and to prevent elopement, prevent the spread of infectious diseases, prevent significant weight loss, and ensure assessments were done timely and fall interventions were implemented. The failure of the facility to ensure competent nursing staff resulted in Immediate Jeopardy for 1 of 5 sampled residents (Resident #5) reviewed for accidents. Resident #5, a vulnerable resident with severe cognition impairment and a positive COVID-19 diagnosis, exited the COVID Unit barrier 3 times by unzipping the barrier, and then exited the facility unsupervised on [DATE]. Resident #5 was found by staff walking on the sidewalk into the parking lot, approximately 223 feet from the facility. Neither Resident #5, nor staff who interacted with him, were using Protective Personal Equipment (PPE), which had the potential to expose staff and other residents to COVID-19. The failure of the facility to ensure competent nursing staff resulted in actual harm for 1 of 3 sampled residents (Resident #3) reviewed for Social Services. Resident #3, a vulnerable resident with diagnoses of Depression, Dementia and COVID-19, sustained a significant weight loss of 7.8 percent (%) in 1 month, after having suicidal ideations and voiced that he wanted to die and would starve himself. Resident #3 was admitted and isolated in the COVID Unit on [DATE] and voiced to Social Services and his family of wanting to die and had suicidal ideations on [DATE]. Resident #3 frequently refused medications and meals, resulting in significant weight loss in 1 month. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator and Interim Director of Nursing (DON) were notified of the Immediate Jeopardy for F-726 on [DATE] at 4:41 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-726. The Immediate Jeopardy existed [DATE] through [DATE]. An acceptable Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] and was validated onsite by the surveyors on [DATE] through [DATE] through policy review, review of education records, medical record review, observation, and staff interviews. The findings include: 1. Review of the facility's undated policy titled, .Personal Protective Equipment, revealed, .To ensure that . PPE .is provided for all staff at the facility, including .facemasks, gloves, gowns, and eye protection .when interacting with COVID-19 suspected or confirmed residents .Prior to entering areas where residents are suspected or confirmed with COVID-19 .Education provided to staff on proper usage, procedure . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, MISSING RESIDENT/ELOPEMENTS, revealed, .The Unit Charge Nurse is responsible for knowing the location of their residents .Missing Resident Guidelines . Determine time and location when last seen . Review of the facility's policy titled, Wandering, Unsafe Resident, Revised ,d+[DATE], revealed, .The facility will strive to prevent unsafe wandering .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .A missing resident is considered a facility-wide emergency .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Contact the Attending Physician and report findings and conditions of the resident . Review of the facility ' s policy titled, Fall Risk Assessment, revised [DATE], revealed, .The nursing staff .will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information .Upon admission, the nursing staff and physician will review a resident ' s record for a history of falls .nursing staff will ask the resident and his/her family about any history of the resident falling .staff and attending physician will .identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable . 2. Review of the Social Worker Job Description revealed, .Ensure that all charted progress notes are informative and descriptive of the services provided and of the resident ' s response to service .review nurses note to determine if the care plan is being followed . Review of the Social Service Director Job Description revealed, .to assure that the medically related emotional and social needs of the resident are met and maintained on an individual basis .make daily rounds to assure that social service personnel are preforming required duties and to assure that appropriate social service procedures are being rendered to meet the needs of the facility .Ensure that all social services personnel are aware of the care plan and that care plans are used in providing daily social service to the residents .review nurses ' notes to determine if the care plan is being followed .communicate with the medical staff, nursing staff . 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of [NAME] ' s Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, Cognitive Social or Emotional Deficit following Cerebral Infarction. Review an elopement risk assessment dated [DATE] revealed Resident #5 had a score of 2 indicating at risk for elopement. Review of a physician ' s order dated [DATE], revealed Resident #5 had an order for a wander guard. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 had severely impaired cognition for daily decision making and required one-person physical assistance walking in his room or in the corridor. Review of a physician ' s order dated [DATE] revealed Resident #5 had an order for contact isolation with droplet precautions r/t Covid positive. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Progress Note dated [DATE] at 11:33 AM, revealed .exit seeking x [times] 3 left COVID hall x 2 this am set off the alarm to door on 700 hall x 1 set off alarm on 500 hall door x 2 found in visitor parking lot per staff member . Review of a Progress Note dated [DATE] at 8:03 PM revealed .off COVID unit x 1 redirected to room . 30-minute checks continue .remains confused at baseline . During a telephone interview on [DATE] at 9:25 AM, the physician stated, .not safe for [Resident #5] to be outside unsupervised .I was not aware of any attempts before this incident . 4. Review of the medical record review for Resident #3 showed an admitted [DATE] with diagnoses of Hypertension, Adult Failure to Thrive, Depression, Insomnia, Personal History of Covid-19, Dementia, Anxiety, Mood Disturbance and Psychotic Disturbance. Review of the physician ' s order dated [DATE] showed .Admit .on COVID Unit d/t [due to] + [positive] COVID test .q [every] 15-minute checks (suicidal ideations) . The facility was unable to provide documentation for the every-15-minute checks as ordered. Review of the admission MDS dated [DATE], showed a BIMS score of 7, which indicated severe cognition impairment, had symptoms of feeling depressed, feeling tired or having little energy, poor appetite or overeating, stated that life isn ' t worth living and wished for death or attempted to harm self, required assistance with activities of daily living, weighed 167 pounds, received oxygen therapy and isolation or quarantine for active infectious disease. Review of the Care Plan initiated date [DATE] showed, .exhibits sad moods .saying negative statements of wanting to die .Observe any changes .check throughout the day .making suicidal statements about killing himself .encourage family to visit often .encourage resident to attend activities .Refer to Psychiatric for evaluation as needed . Review of the Social Services note dated [DATE] showed, .resident began expressing suicidal ideations stating he wanted to die and not live anymore. The resident was refusing to eat, refusing meds removing his oxygen and telling his family and staff that he wanted to die. The SW told the family she would ask for a Psychiatric (Psych) referral for the resident .Window visits with daughter . The facility was unable to provide documentation of Social Services follow-up interventions for Resident #3 for Depression with suicidal ideations and refusal of mediations and meals from [DATE] until resident expired [DATE]. Review of the physician ' s order dated [DATE] showed, .psych [Psychiatric]-eval[evaluation] refusing to eat . Review of the [NAMED] PHYSICIANS ORDER FOR PSYMED SERVICES dated [DATE] documented . thoughts of dying .ordering referral for psychiatry services . The Psychiatric Nurse Practitioner did not see Resident #3 until [DATE], 13 days after Resident #3 expressed suicidal ideations and after the physician ordered the psychiatric services. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Care Plan dated [DATE] showed, .at risk for loneliness, anxiety and sadness related to isolation precautions implemented due to COVID 19 .interventions .observe resident for S/S [Signs and Symptoms] of social isolation or .depression .Resident to talk or facetime family/friends as per resident/family request and as needed . Review of the significant change MDS dated [DATE], showed a BIMS score of 6 indicating severe cognition impairment, requires assistance with activities of daily living, weighed 140 pounds with loss of 5% or more in the last month, had 2 stage 2 pressure ulcers, and received antidepressant medication. Review of the physician ' s order dated [DATE], showed, .Palliative Care . Resident #3 expired on [DATE]. 5. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses of Cancer of Larynx, Supraglottis and Pharynx, Dementia, Anxiety, Aphonia, and a History of COVID 19. Review of the quarterly MDS dated [DATE], revealed a BIMs score of 10, indicating moderate cognition impairment, required assistance with activities of daily living, had unclear speech, was sometimes understood, made needs known by pointing and use of electrolarynx, had moderately impaired vision, and had behaviors. Review of the Care Plan dated [DATE], revealed, .has a potential to demonstrate physical aggressive behavior .resident to resident altercation .Psych consult . During an interview on [DATE] at 10:51 AM, the PNP confirmed she did not see Resident #12, and that she was unaware she was supposed to see him. During an interview on [DATE] at 5:00 PM, the Social Services Director (SSD) confirmed she was unaware Resident #12 had not been seen by the PNP until the surveyor asked for the psychiatric note, and that follow-up notes should have been documented. The SSD was unable to provide the Psychiatric referral sheet for Resident #12. The SSD was asked if 2 residents were in an altercation, should Social Services evaluate and document both. The SSD stated, .yes, they should . Resident #12 was involved in a resident-to-resident altercation and hit another resident on [DATE]. The facility failed to provide Social Services monitoring and was unable to provide a psychiatric services referral documentation. 6. Medical record review revealed Resident #9 was admitted on [DATE], with diagnoses Cerebral Infarction, Anemia, History of Falling, Metabolic Encephalopathy, Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of the admission fall risk assessment dated [DATE] revealed the assessment was incomplete. Review of the admission assessment dated [DATE] revealed assessment was not signed until [DATE]. (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the baseline Care Plan dated [DATE] revealed Resident #9 was at risk for falls related to new and unfamiliar environment, poor safety awareness, unsteady gait and weakness. The interventions were to anticipate and meet resident ' s needs as needed and keep room free of clutter and obstacles that may pose trip hazards. Review of the MDS dated [DATE] revealed Resident #9 had a history of falls prior to admission. Review of the Incident Details Report dated [DATE] revealed, .CNA [Certified Nursing Assistant] called for the nurse to come to the resident ' s room. Resident was found on the floor .resident has right side head injury with a raised area over the eye .hematoma forehead . Resident #9 ' s admission assessment and fall risk assessment were not completed. The baseline care plan did not include person centered measurable interventions to prevent falls. Resident #9 fell on [DATE] and sustained a hematoma to the right side of her face. During an interview on [DATE] at 11:31 AM, the Interim DON stated, .the admission assessment should be completed within 24 hours of admission .fall risk assessments are completed upon admission and when a fall occurs . The Interim DON confirmed Resident #9 ' s admission assessment was not completed within 24 hours of admission and the admission fall risk assessment was not completed. 7. Review of a closed medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses of Anemia, Cerebral Infarction, and Esophagitis. Review of the fall risk assessment dated [DATE], revealed Resident #2 was assessed at moderate risk for falls. Review of the admission MDS dated [DATE], revealed Resident #2 was assessed with a BIMS of 11 indicating moderate cognitive impairment for decision making. Resident #2 required assistance with activities of daily living. Review of the Care Plan revised [DATE], revealed fall interventions to anticipate and meet resident's needs, and physical therapy to evaluate and treat as ordered and as needed. Review of the Incidents by Incident Type report dated [DATE] through [DATE], revealed Resident #2 was not listed as having a fall on [DATE]. During an interview on [DATE] at 10:54 AM, the DON confirmed Resident #2 had a fall on [DATE]. The DON stated, The CNA did not report the fall to the charge nurse .I received the information on [DATE] .in-serviced staff .talked to them about reporting falls .didn't have them sign anything .a fall investigation was completed the next day .a fall risk assessment was not completed after the fall . There were no noted injuries to Resident #2. During a telephone interview on [DATE] at 10:37 AM, CNA #3 stated, .yes [Resident #2] was in the floor I helped [CNA #4 and #5] get her up into the wheelchair .no I did not report it to the nurse . Review of personnel files for CNA #3, CNA #4, and CNA #5 on [DATE], revealed there were no disciplinary actions or education provided related to reporting falls. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 11:05 AM, the DON confirmed the fall investigation was not signed by the staff completing the investigation. During a telephone interview on [DATE] at 3:40 PM, the Chief Operations Officer stated, .fall investigation should be signed .fall risk assessments should be completed after a fall and on admission .if staff observe a fall and do not report it to the nurse, the staff are educated and disciplined .should be in their personnel record . 8. Observation on [DATE] at 2:15 PM, revealed LPN #3 on 200 hall Nurses ' Station sitting at the computer with her eyes closed and nodding her head asleep at the desk. During an interview on [DATE] at 3:50 PM, the Interim DON stated, .staff should not be sleeping while working here at this facility .I have spoke [spoken] with LPN #3, and she has begged me for another chance . Observation on [DATE] at 1:50 PM, revealed CNA #2 sitting outside of a room on the 800 hall in a chair beside a linen cart with her head slumped over and eyes closed. During an interview on [DATE] at 2:10 PM, CNA #2 stated, .I apologize for sleeping. I ' ve been here since yesterday . During an interview on [DATE] at 12:55 PM, the Administrator stated, .it is not acceptable for staff to be sleeping on duty . The surveyors verified the Allegation of Compliance Removal Plan through record review, observations, audit reviews, review of education and sign-in sheets, and interviews for the immediate corrective actions listed below: 1. The facility will conduct an audit to ensure admission assessments were completed on all new admissions for the past 30 days. This audit will be completed by [DATE]. The DON/ADON/Unit Managers will be responsible. Any missing assessments will be completed immediately. The surveyors reviewed the audit form. The surveyors interviewed the DON, the Assistant Director of Nursing (ADON) and the Unit Managers regarding admission assessments, reviewed Resident #9 ' s assessments to ensure completion. 2. The facility will conduct an audit to ensure fall assessments were completed upon admission and following fall incidents for the past 30 days. This audit will be completed by [DATE]. The DON/ADON/Unit Managers will be responsible. Any missing fall risk assessments will be completed immediately. The surveyors interviewed the DON, the ADON, and the Unit Managers regarding admission fall risk assessments. 3. All employees were educated on incident and accident supervision. All staff have been educated on Incidents and Accidents, and monitoring has been completed. Education included thorough and timely completion of resident assessments, monitoring, and provision of safety for all residents, and thorough investigations of all incidents and accidents to include all potential witness statements in the event of elopement. The surveyors interviewed staff on all shifts, reviewed the in-service education and sign-in sheet. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. The Administrator/DON have been consulted regarding proper reporting in a timely manner per state regulation and conducting thorough investigations with all Incidents and Accidents. The ADON/Unit Managers were educated on proper monitoring and supervision, incidents and accidents, proper investigating and reporting. Unit Managers were educated on proper and thorough assessments to be completed in a timely manner. The surveyors interviewed the Administrator, the DON, the ADON and the Unit Managers regarding proper reporting, investigation, supervision, and monitoring. 5. DON/ADON/Unit Managers will audit and review any uncompleted assessments daily in the clinical meetings. The findings will be reported to the monthly QAPI committee meetings for follow-up. The surveyors interviewed the Administrator, the DON, the ADON and the Unit Managers regarding proper reporting, investigation, supervision and monitoring. The facility's noncompliance of F-726 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, review of the Social Worker job description, medical record review, and interview the facility failed to provide effective social services to maintain the highest practicable physical, mental, and psychosocial well-being for residents coping with Depression, social isolation, suicidal ideations, and exit-seeking and aggressive behaviors for 4 of 6 (Resident #3, #5, #9, and #12) sampled residents reviewed for Social Services. The failure of the facility to ensure Social Services provided or arranged needed mental and psychosocial services resulted in actual Harm to Resident #3. Resident #3 admitted with diagnoses of Depression, Dementia and COVID-19. He was admitted to the COVID Unit and placed in contact isolation. He voiced suicidal ideations 3 days after admission, stating he wanted to die, and that he would starve himself. Resident #3 refused medications and meals resulting in 7.8 percent (%) weight loss in 1 month. The facility was unable to provide documentation of Social Services follow-up related to Depression, suicidal ideations, refusal of medications/meals and weight loss. The findings include: 1. Review of the Social Service Policy dated [DATE], revealed, .will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .Definitions: Medically-related social services are services provided by the facility's staff to assist residents in attainment or maintenance of a resident's highest practicable well-being .The social worker, or social service designee, will complete an initial .identifying any need for medically-related social services of the resident. Any need for medically related social services will be documented in the medical record .The social worker, or social service designee, will pursue the provision of any identified need for medically related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include .Providing or arranging for needed mental and psychosocial counseling services .identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident .Meeting the needs of residents who are .coping with stressful events .The facility should provide social services or obtain needed services from outside entities during situations that include .Expressions or indications of distress that affect the resident's mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis) .Difficulty coping with change or loss .change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one .Need for emotional support .The resident's plan of care will reflect any ongoing medically-related social service needs, and how these needs are being addressed .The social worker, or social service designee, will monitor the resident's progress in improving physical, mental, and psychosocial functioning . (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	2. Review of the Social Worker Job Description revealed, .the primary purpose of your position is to assist in planning, organizing, implementing, evaluating and directing .to assure that the medically related emotional and social needs of the resident are met and maintained on an individual basis .Ensure that all charted progress notes are informative and descriptive of the services provided and of the resident's response to service .review nurses notes to determine if the care plan is being followed . 3. Review of the Social Service Director Job Description revealed, .the primary purpose of your position is to assist in planning, organizing, implementing, evaluating and directing .to assure that the medically related emotional and social needs of the resident are met and maintained on an individual basis .make daily rounds to assure that social service personnel are performing required duties and to assure that appropriate social service procedures are being rendered to meet the needs of the facility .Ensure that all social services personnel are aware of the care plan and that care plans are used in providing daily social service to the residents .review nurses' notes to determine if the care plan is being followed .communicate with the medical staff, nursing staff . 4. Review of the medical record revealed Resident # 3 was admitted to the facility on [DATE], with diagnoses of Depression, Dementia, Anxiety, Mood Disturbance, Psychotic Disturbance, Adult Failure to Thrive, Insomnia, Personal History of Covid-19, Disorder of Thyroid, and Hypertension. Review of the Physician's order dated [DATE] showed, .Admit .on COVID Unit d/t [due to] + [positive] COVID test .q[every] 15-minute checks (suicidal ideations) . The facility was unable to provide documentation of the every-15-minutes checks ordered on [DATE] due to suicidal ideations. Review of the admission Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognition impairment. The MDS revealed Resident #3 had symptoms present of feeling depressed, feeling tired or having little energy, poor appetite or overeating, stated that life wasn't worth living, wished for death or attempted to harm himself several days. The MDS revealed Resident #3 required assistance with bed mobility, dressing, toilet use, and personal hygiene, weighed 167 pounds, received oxygen therapy, and was in isolation or quarantine for active infectious disease. Review of the Care Plan dated [DATE], documented, .exhibits sad moods .saying negative statements of wanting to die .Observe any changes .psych [psychiatric services] as needed .check throughout the day .is making suicidal statements about killing himself with interventions .encourage family to visit often .encourage resident to attend activities .Refer to Psychiatric for evaluation as needed . Review of the Physician's order dated [DATE] showed, .psych eval [evaluation] .refusing to eat . Review of the [NAMED] PHYSICIANS ORDER FOR [Named psychiatric consult group] SERVICES dated [DATE] documented, .thoughts of dying .ordering referral for psychiatry services . (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Review of the Social Services note dated [DATE], showed, .resident began expressing suicidal ideations stating he wanted to die and not live anymore. The resident was refusing to eat, refusing meds [medications] removing his oxygen and telling his family and staff that he wanted to die. The SW [Social Worker] told the family she would ask for a Psychiatric (Psych) referral for the resident .Window visits with daughter. The facility was unable to provide documentation for Social Services follow-up interventions for Resident #3, who had a diagnosis of Depression, refusal of mediations/meals, and expressed suicidal ideations, from [DATE] until the resident expired on [DATE]. Review of the Care Plan dated [DATE], documented, .at risk for loneliness, anxiety and sadness related to isolation precautions .COVID 19 .Interventions .observe resident for S/S [Signs and Symptoms] of social isolation or .depression .Resident to talk or facetime family/friends as per resident/family request and as needed . Review of the Initial Psychiatric Evaluation dated [DATE] documented, .chief complaint/reason for referral . psychiatric evaluation and medication management .Upon approach patient guarded and became hostile during assessment .Remeron [an antidepressant medication also used to increase appetite] was initiated . clinical impression .patient with dementia and various medical ailments .will continue to monitor closely and support .Medication Orders/Recommendations Depakote Sprinkles [a medication used as a mood stabilizer] . follow up ,d+[DATE] weeks . Review of the Dietician note dated [DATE], documented, .Resident noted with weight loss of 4.5% x [times] 1 week to weight of 156.4# [pounds] .BMI [Body Mass index] of 20.0 [Normal adult BMI is 18.5 - 24.9] .receives a NAS [No added sodium] diet with poor po [oral] intake .resident has been refusing meals, meds and supplement .Ensure most days, but will refuse at times .Resident remains at increased risk for further weight loss due to refusal of meals, supplements . Review of the Psychiatric Follow Up Note dated [DATE] documented, .Patient resting upon approach, did not engage .Nurse reports patient with noncompliance refusing meds and continued poor appetite .continues agitations and combative behavior .symptoms not contained due to noncompliance .Follow up schedule , d+[DATE] weeks .Medication orders/ Recommendation .Olanzapine [an antipsychotic medication] . There was no documentation of any psychiatric follow-up or visits after [DATE]. Review of the Dietician note dated [DATE], documented, .Resident has refused to be weighed for the weeks of [DATE] and [DATE] . Review of the Dietician note dated [DATE], documented, .weight loss of 7.3% x 1 month to weight of 140# . Resident often refuses to be weighed .BMI of 17.9, underweight .Resident receives a NAS diet with poor po intake noted .often refuses meals and meds . Review of the Physician's order dated [DATE], showed, .Admit to COVID Unit .roommate tested positive . (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Review of the significant change MDS dated [DATE], showed a BIMS score of 6, indicating severe cognition impairment, required assistance for bed mobility, dressing, toilet use, personal hygiene, and eating, weighed 140 pounds with a loss of 5% or more in the last month, had 2 stage 2 pressure ulcers, and received antidepressant medication. Review of the Physician's order dated [DATE], showed, .Palliative Care . Review of the Dietician note dated [DATE], documented, .Resident admitted to Palliative Care [DATE] . Weights have been DC'd [discontinued] .Resident continues with decreased po intake . Interview on [DATE] at 10:51 AM, the Psychiatric Nurse Practitioner (PNP) stated, .I got a referral about him [Resident #3] not eating .when I came to see, he was very hostile, so I ordered some medications to go along with what he was on .he was not suicidal during my initial visit .exhibiting aggressive and combative behavior .the problem I'm having is no documentation of behaviors, not getting referrals from the Social Worker. I have not attended any behavior meetings .don't know if they have them .the referrals are not getting sent into the office timely .the facility will want to send residents out [to Psychiatric Unit], but there is nothing charted in the notes, or either psych as not seen them .the Medical Doctor is being called for orders for behaviors instead of them calling me or letting me know .there is a problem with the documentation of behaviors by the nurses or whoever .They [facility] want to send them out .there is nothing documented to send them out . During an interview on [DATE] at 12:25 PM, the Social Services Director (SSD) confirmed there was no follow-up documentation regarding suicidal ideations, meal/medication refusals, and Depression for Resident #3. The SSD stated, .there should be documentation to show we followed up . The SSD confirmed there was a delay in referrals to psychiatric services. The Social Services Director stated, .the process is broken, we [Social Services] are not included in the clinical meeting, and some residents are not seen timely . During an interview on [DATE] at 5:00 PM, the SSD was asked if Resident #3 was seen [DATE] when the referral was made [DATE], and why he was seen. The SSD stated, The Psych NP seen [saw] him because he was not eating .There is a problem with the documentation, and what the NP is informed .There should have been follow-up documentation from Social Services regarding the suicidal ideations, at least daily checks . The SSD was asked if there was any documentation from Social Services to show follow-up, or where Social Services provided interventions to address the Depression and refusal of medications/meals. The SSD stated, .No there is not any .but definitely should have been . The SSD confirmed no one made rounds with the PNP, and if there had been follow-up documentation about Resident #3's suicidal ideations, then the PNP would have known to address this. The failure of the facility to ensure Social Services provided or arranged needed mental and psychosocial services resulted in actual Harm to Resident #3 when he suffered from a diagnosis of Depression, expressed suicidal ideations, refused to eat, and had a significant weight loss of 7.3% in 1 month. 5. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, and Cognitive Social or Emotional Deficit following Cerebral Infarction. (continued on next page)

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan dated [DATE], revealed Resident #5 was at risk for elopement related to poor safety awareness, was at risk for falls, had impaired cognitive function, and was at risk for loneliness, anxiety and sadness related to isolation precautions related to COVID-19. Review of an elopement risk assessment dated [DATE] revealed Resident #5 was assessed at risk for elopement. Review of the admission MDS dated [DATE], revealed Resident #5 was severely cognitively impaired for daily decision making and required one-person physical assistance with walking in his room or in the corridor. Review of a physician's order dated [DATE] revealed Resident #5 had an order for contact isolation with droplet precautions related to a positive Covid diagnosis. Review of a Progress Note dated [DATE] at 11:33 AM, revealed, .exit seeking x [times] 3 left COVID hall x 2 this am set off the alarm to door on 700 hall x 1 set off alarm on 500 hall door x 2 found in visitor parking lot per staff member . Review of a physician's order dated [DATE] revealed Resident #5 had an order for psychiatric services. Review of a Progress Note dated [DATE] at 8:03 PM, revealed, .off COVID unit x 1 redirected to room . 30-minute checks continue .remains confused at baseline .remains on COVID unit with droplet precautions and contact isolation . Review of a physician's order dated [DATE] revealed Resident #5 had an order for psychiatric services to evaluate and treat for behavior. Review of a Social Services note dated [DATE] revealed, .visited with [Resident #5] to let him talk to his brother .he was glad to hear his voice . During an interview on [DATE] at 12:58 PM, CNA #1 stated, .yes, I was assigned to care for [Resident #5] on [DATE] .he had got out of the unit [Covid Unit] a couple of times that day .I helped the nurse get him back in the COVID unit .about 20 minutes after that I got a phone call from the [Activities Director] telling me he was outside . During an interview on [DATE] at 10:54 AM, the Administrator confirmed Resident #5 had exited the Covid Unit several times on [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:51 AM, the PNP stated, I did not see, nor was I aware of the elopement [by Resident #5] on the 30th [[DATE]], until I was called and asked if I could make a note about him to get him sent out [to psychiatric unit] .I was in the building on the 10th [[DATE]], and no one said anything .I face timed him on the 11th [[DATE]] .I didn't know he had gotten out of the building, or that he had previously attempted to exit the facility .Residents can be sent out if they have COVID. There was no documentation of [Resident #5's exit-seeking] behaviors. That's the reason they [behavioral health facility] didn't accept him, not because he had COVID .you have to have documentation of behaviors when you want them sent out . The problem I'm having is no documentation of behaviors, not getting the referrals from the Social Worker . I've not attended any behavior meetings or been asked to .The system is broken . During an interview on [DATE] at 5:00 PM, the SSD confirmed Resident #5 was not seen by the PNP until [DATE], stating, We were not aware the resident hadn't been seen by Psych until we were asked for the notes .I don't know why he [Resident #5] was not seen by the Psych NP when she made rounds [[DATE]] . He should have been seen before the 10th [[DATE]] .We should have been following up . The facility failed to provide timely psychiatric services, Social Services monitoring regarding elopement or wandering behaviors and follow-up documentation for Resident #5 when he exited the facility unsupervised. Resident #5 was not seen by the PNP until [DATE], 12 days after the elopement incident occurred. 6. Medical record review revealed Resident #9 was admitted to the facility on [DATE], with diagnoses of Cerebral Infarction, Anemia, History of Falling, Metabolic Encephalopathy, Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of the MDS dated [DATE], revealed Resident #9 was assessed by staff as having severe cognitive impairment for decision making, trouble concentrating, exhibited behaviors including rejection of care and wandering, and required one-person limited assistance with activities of daily living. Review of a physician's order dated [DATE], revealed a referral for psychiatric services for the diagnosis of Dementia. Review of the baseline Care Plan dated [DATE], revealed Resident #9 was at risk for loneliness, anxiety and sadness related to isolation precautions implemented due to COVID 19, with a goal of adherence to the Centers for Disease Control (CDC) COVID guidelines and to be free from signs and symptoms of social isolation. Interventions included Activities staff to visit as needed, observe Resident #9 for signs and symptoms of social isolation or of depression, and Resident #9 was to talk/facetime with family/friends as per resident/family request and as needed. Review of a physician's order dated [DATE], revealed, .Olanzapine [an antipsychotic medication] 5mg [milligrams] IM [intramuscular] q [every] 12hr [hours] prn [as needed] behavioral and psychological symptoms of dementia XXX[DATE] Risperdal [an antipsychotic medication] .25mg po [orally] bid [twice a day] XXX[DATE] .Risperdal .5mg po at bedtime . Review of a physician's order dated [DATE] revealed, .Megace [an appetite stimulating medication] for unspecified dementia . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0745 Level of Harm - Actual harm Residents Affected - Few	Review of a Social Services note dated [DATE] revealed, .Phone call made to [Resident Representative] in regards [Resident #9] .unable to reach anyone, no voicemail was set up. Will continue to assist as needed . During an interview on [DATE] at 5:00 PM, the Social Services Director (SSD) was asked for Resident #9's psychiatric referral. The SSD stated, It should be in the book, but it is not. There is no referral sheet . The SSD was asked how the PNP knew to see the residents without a referral sheet. The SSD stated, Probably not, because it has to be faxed over to her office to get on the list .she will see them if they are on her list . We do not know who is on her list when she comes or who is being seen .usually we get her notes within a week . The SSD was asked if she confirmed that Resident #9's orders were faxed. The SSD stated, .no, if the sheet is not in the book. I can't find a sheet for her .the sheet is the order. The SSD was asked if Social Services should follow up on referrals, psychiatric medications and behaviors. The SSD stated, Yes, we should have a system to know who is being seen by the Psych NP, and if there are any behaviors, but there is no communication with the clinical side, and the system is broken. We don't have an effective way of communicating with the Psych NP .we don't know who she has on her list, or who is being seen .most definitely we should be following up and making documentation on the resident .there are no Psych NP notes for [Resident #9] . Resident #9, a vulnerable resident with severe cognition impairment and diagnosed with Dementia, had antipsychotic medications ordered for behaviors and a physician's order for a psychiatric referral on [DATE]. The facility failed to provide an appropriate and timely psychiatric services referral, social services monitoring and follow-up documentation. Resident #9 was not seen by the PNP until [DATE], 19 days after the referral was made. 7. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses of Cancer of Larynx, Supraglottis and Pharynx, Dementia, Anxiety, Aphonia, and a History of COVID 19. Review of the quarerly MDS dated [DATE] revealed a BIMs score of 10, indicating moderate cognition impairment, required limited assistance with bed mobility, dressing and toilet use. The MDS revealed Resident #12 had unclear speech, was sometimes understood, made needs known by pointing and use of electrolarynx, had moderately impaired vision, and was being monitored every 30 minutes for behaviors. Review of the Care Plan dated [DATE], revealed, .has a potential to demonstrate physical aggressive behavior .resident to resident altercation .with interventions .Psych consult . During an interview on [DATE] at 10:51 AM, the PNP stated, .I did not get the referral for that resident [Resident #12]. I was in the building, and I saw the other resident the next day. I heard them [staff] talking at the desk, so I went to see him [the other resident involved in the altercation], but did not see [Resident #12] . he was not on my list to be seen .I don't have anything to say I need to see him . During an interview on [DATE] at 5:00 PM, the SSD confirmed the Psychiatric referral sheet could not be located. The SSD further confirmed she was unaware Resident #12 had not been seen by the PNP until the surveyor asked for the psychiatric note, and that follow-up notes should have been documented. The SSD was asked if 2 residents were in an altercation, should Social Services evaluate and document. The SSD stated, .yes, they should . (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

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F 0745 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:00 PM, the Interim Director of Nursing (DON) confirmed the PNP should have evaluated Resident #12 after the resident-to-resident altercation incident on [DATE]. The Interim DON confirmed there was a systems problem regarding the process of getting psychiatric referrals and getting the residents seen timely by the PNP. The Interim DON further confirmed that residents receiving medications for behaviors and exhibiting behaviors should be discussed with the clinical staff and Social Services staff and relayed to psychiatric services. The Interim DON stated, I don't know where the break-down is, but this is definitely a problem. Resident #12 was involved in a resident-to-resident altercation and hit another resident on [DATE]. The facility failed to provide Social Services monitoring and was unable to provide psychiatric services referral documentation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31839 Based on the Board of Examiners of Nursing Home Administrators (BENHA) review, job description review, medical record review, and interview, the facility Administration failed to provide supervision and oversight to prevent the potential for serious injury when Resident #5 exited the Covid Unit and eloped from the facility on 10/30/2022. Resident #5 walked outside the facility, and down the sidewalk toward a parking lot approximately 223 feet from the facility and was unsupervised for approximately 6 minutes. Administration failed to identify breaches in Infection Control practices when Licensed Practical Nurse (LPN) #1 and Certified Nurse Assistant (CNA) #1 were not wearing Personal Protective Equipment (PPE) when providing care for Resident #5, who was Covid Positive. Administration failed to identify incomplete admission and fall risk assessments, failed to ensure measurable and person-centered interventions were in place to prevent falls, and failed to provide in-service education for facility staff related to fall reporting for 2 of 3 sampled residents (Resident #9 and #2) reviewed for falls. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, the Interim Director of Nursing (DON), and the Chief Operating Officer (COO) were notified of the Immediate Jeopardy on 12/2/2022 at 8:52 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, F-689, F-725, F-726, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, and F-689 at a scope and severity of J, which is Substandard Quality of Care. The facility was cited an Immediate Jeopardy at a J on 8/30/2021 for deficiencies related to F-600, F-610, F-689, F-725, F-726, F-835 and F-867. The facility was cited an Immediate Jeopardy at a J on 2/10/2020 for deficiencies related to F-600, F-610, F-689, F-835 and F-867. The Immediate Jeopardy was existed from 10/30/2022 through 12/2/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/14/2022 at 12:44 PM, and was validated onsite by the surveyors on 12/1/2022 - 12/2/2022 through observations, review of audits, meeting minutes, and staff interviews. The findings include: Review of the BENHA revealed the Administrator had an employment date of 7/6/2020. (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Administrator job description, signed by the Administrator on 7/6/2020, revealed, .The primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .As Administrator, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties . Administrative Functions .Plan, develop, organize, implement, evaluate, and direct the Facility's programs and activities in accordance with guidelines issued by the VP [Vice President] of Operations .Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the Facility .realize the importance of teamwork .Review the Facility's policies and procedures at least annually and make changes as necessary to assure continued compliance with current regulations .Ensure that all employees, residents, visitors, and the general public follow the Facility's established policies and procedures .Represent the Facility in dealings with outside agencies, including governmental agencies . Participate in state/federal surveys of the facility .Assist in providing survey team members with additional information during the survey .Review deficiencies noted during the exit conference .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies .Consult with department directors concerning the operation of their departments to assist in eliminating and correcting problem areas .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents .Review and check competence of work force and make necessary adjustments or corrections .Inform the Medical Director of all suspected or known incidents of resident abuse .Ensure the building and grounds are maintained in good repair .Review accident/incident reports .Monitor to determine the effectiveness of the facility's risk management program .Specific Requirements .Must have a thorough knowledge of OBRA [Omnibus Budget Reconciliation Act] regulations, the survey process, survey tag numbers, and quality measures .Must be able to communicate policies, procedures, regulations, reports .to government agencies and personnel . (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Director of Nursing Services job description, signed by the DON on 3/16/2020, revealed .The primary purpose of your position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility .you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. In the absence of the Medical Director, you are charged with carrying out the resident care policies established by the Facility .Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Develop, implement, and maintain an ongoing quality assurance program for the nursing service department .Assist the Quality Assessment & [and] Assurance Committee (QAPI) in developing and implementing appropriate plans of action to correct identified deficiencies .Make daily rounds of your unit/shift to ensure that assigned CNAs [Certified Nursing Assistants] .and other nursing personnel are performing their work assignments in accordance with acceptable nursing standards .Make changes to assignments based upon resident needs . Determine the staffing needs of the nursing service department necessary to meet the total nursing needs of the residents .Assign a sufficient number of LPNs [Licensed Practical Nurses] and RNs [Registered Nurses] for each tour of duty to ensure that quality care is maintained .Assign a sufficient number of CNAs for each tour of duty to ensure that routine nursing care is provided to meet the daily nursing care needs of each resident .Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care .Develop and participate in the planning, conducting, and scheduling of timely in-service training classes that provide instructions on how to do the job, and ensure a well-educated nursing service department .Monitor nursing service personnel to ensure that they are following established safety regulations in the use of equipment and supplies .Review and revise care plans and assessments as necessary .Report all allegations of resident abuse .Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to nursing care facilities . During an interview on 11/3/2022 at 11:17 AM, the DON stated, .I was notified the day [Resident #5] exited the facility .the investigation wasn't started until 10/31/2022, and it has not been reported . During an interview on 11/3/2022 at 11:17 AM, the Administrator stated, .the investigation started on 10/31/2022 after the morning meeting .I notified the [Chief Operating Officer] and was told to continue the investigation and collect statements .the COO agreed it was not a reportable incident at this point . During an interview on 11/8/2022 at 4:36 PM, the DON stated, .I did not direct the RN [Registered Nurse] Supervisor to gather statements the day she notified me of the incident . During and interview on 11/9/2022 at 11:00 AM, the Administrator confirmed staffing concerns had not been investigated until 11/8/2022. During an interview on 11/9/2022 at 12:27 PM, the COO stated, .I was notified of the incident on [10/31/2022] and directed them [Administration] to continue the investigation and collect statements .I spoke with Administrator on Wednesday [11/22/2022] and directed them to report the incident into [Incident Reporting System]. I assumed they had reported it that day . (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/10/2022 at 10:54 AM, the Administrator stated, .the DON should have come in . gave directions about getting staff statements .the investigation was not started immediately .on Monday [10/31/2022] the only information we had was RN #1's statement that was based on what she was told . Monday I told the DON an incident report and a head-to-toe assessment needed to be completed . During an interview on 11/21/2022 at 3:30 PM, the COO stated, .incidents should be reported to the DON then to the Administrator .the DON took it upon herself to not report the incident to the Administrator . statements should be obtained immediately .incident reports should be completed by the charge nurse . During an interview on 11/22/2022 at 3:40 PM, the Administrator stated, .this is the 3rd elopement for us .this is the same thing that happened last year [2021]. The [DON] failed to notify me about the incident when it happened .I am supposed to be notified of these incidents .did not report it timely because did not think it was reportable since staff had their eyes on him .now were are finding out statements and assessments that should have been done but were not .and I'm just finding out about them . During an interview on 11/22/2022 at 3:50 PM, the Interim DON stated, .admission assessments should be completed within 24 hours of admission .fall risk assessments are completed upon admission .and after a fall . The facility's noncompliance of F-835 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31839 Based on policy review, Quality Assurance Performance Improvement (QAPI) Committee meeting review, job description review, and interview, the QAPI committee failed to ensure an effective QAPI program that identified opportunities for improvement related to resident safety and infection control, and failed to implement performance improvement activities in order to provide a safe environment for residents, prevent the spread of infections, and ensure systems and processes were in place and were consistently followed by staff and administration. The QAPI committee failed to provide oversight that established and implemented policies and procedures to ensure the facility was administered in a manner to use its resources effectively and efficiently. The failure of the QAPI committee to ensure systems and processes were in place and consistently followed by staff and administration placed Resident #5, a COVID-positive resident with exit-seeking behaviors, in Immediate Jeopardy when he exited the COVID Unit barriers 3 times, and then exited the facility unsupervised. Staff was unaware Resident #5 was missing from the facility until he was seen by a staff member walking outside the facility, down the sidewalk and into the back parking lot approximately 223 feet from the 800 hall exit door. Contact isolation was not maintained, which had the potential to spread COVID-19 infection to staff and residents. The failure of the QAPI committee to ensure systems and processes were in place and consistently followed by staff and administration resulted in actual harm for Resident #3, who sustained a 7.8 percent weight loss in 1 month. Resident #3 admitted with Depression, Dementia and a positive COVID diagnosis. He was admitted to the COVID Unit in contact isolation and voiced suicidal ideations 3 days after admission by stating he wanted to die and would starve himself. The facility was unable to provide documentation of follow-up by Social Services for Resident #3. Resident #3 was not provided needed psychiatric services for days after expression of suicidal ideations. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing (DON), and the Chief Operating Officer (COO) were notified of the Immediate Jeopardy on 12/2/2022 at 8:52 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-600, F-609, F-610 and F-689, F-725, F-726, F-835, and F-867. The facility was cited Immediate Jeopardy at F-600, F-609, F-610, and F-689, at a scope and severity of J, which is Substandard Quality of Care. The facility was cited an Immediate Jeopardy at a J on 8/30/2021 for deficiencies related to F-600, F-610, F-689, F-725, F-726, F-835 and F-867. The facility was cited an Immediate Jeopardy at a J on 2/10/2020 for deficiencies related to F-600, F-610, F-689, F-835 and F-867. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Immediate Jeopardy existed 10/30/2022 through 12/2/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 12/2/2022 at 8:52 PM. The Removal Plan for QAPI was validated by the surveyors with additional education put in place on 12/2/2022 and the removal of the F600, F609, F610, F689, F725, F726, F835, and F880 IJs. The findings include: Review of the facility policy titled, QA [Quality Assurance] Committee-Role of the Quality Assessment and Assurance Coordinator, revised 11/2010, revealed, .Duties and responsibilities of the Quality Assessment and Assurance Program include, but are not limited to: .Meeting with the Quality Assessment and Assurance Committee monthly to review all assessment tools designed, all data collection reports, and all activities regarding quality assessment and assurance as carried out by departments, services, or committees which have a direct impact on resident care and safety .planning developing, organizing, implementing, coordinating, and directing the Quality Assessment and Assurance program designed to enhance the quality of resident care, in accordance with current rules, regulations, and guidelines that govern the long-term care facility .Evaluating programs and effecting changes as necessary to improve programs and assuring compliance with regulatory requirements .Assisting department directors in developing and implementing appropriate plans of action to correct identified deficiencies .Scheduling committee meetings and notifying members of such meetings .Assisting in developing follow-up procedures for monitoring identified problem areas . Review of the facility's policy titled, Wandering, Unsafe Resident, revised 8/2014, revealed, .The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) .The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering .When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall .Complete and file an incident report; and Document relevant information in the resident's medical record . Review of the Administrator Job Description, signed by the Administrator on 7/6/2020, revealed, .The primary purpose of your position is to direct day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times .Committee Functions Serve on various committees of the Facility (i.e. Infection Control, Quality Assurance and Assessment, etc. and provide written and oral reports of such committee meetings to the VP [Vice President] of Operations .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified quality deficiencies. Evaluate and implement recommendations from the Facility's committee as necessary . (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Director of Nursing Services Job Description, signed by the Director of Nursing on 3/16/2020, revealed, .The primary purpose of your position is to plan, organize, develop, and direct the overall operation of our Nursing Services Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator or the Medical Director to ensure that the highest degree of quality care is maintained at all times .Duties and responsibilities .Plan, develop, organize, implement, evaluate, and direct the nursing services department, as well as its programs and activities in accordance with current rules, regulations, and guidelines that govern the nursing care facilities .Develop, implement, and maintain an ongoing quality assurance program for the nursing service department .Assist the Quality Assurance and Assessment Committee in developing and implementing appropriate plans of action to correct identified deficiencies . Review of the QAPI meeting minutes provided by the Administrator, revealed a QAPI Committee meeting was held on 10/21/2022, to address a COVID-19 outbreak in the facility, and a recommendation was made for designated staffing for the COVID Unit to reduce further spread of the virus with staff and residents. The designated staff should consist of 1 nurse, 1 certified nursing assistant (CNA) and 1 housekeeper on the COVID Unit. On 10/30/2022, this was not followed, as staff assigned to the COVID Unit also cared for residents outside the COVID Unit on other halls. The QAPI meeting held on 10/31/2022, did not address designated staffing of the COVID Unit. There was no immediate action taken by the QAPI Committee to staff the COVID Unit with designated staff until 11/10/2022. During an interview on 11/9/2022 at 12:27 PM, the COO stated, .when I was notified, I told them [Administrator and DON] on 10/31/22 .They told me that a resident was found outside .told them to continue the investigation and get statements .on Wednesday [11/2/2022] I told them to report it, and I was under the assumption it was reported Wednesday [11/2/2022] . During an interview on 11/8/2022 at 4:36 PM, the Administrator stated, During our QAPI [meeting] on 10/21 [2022], we had a meeting regarding the COVID outbreak. We decided that we would have designated staffing in the Covid Unit: 1 nurse, 1 CNA, and 1 housekeeper . The Administrator was asked if the designated staff assigned to the COVID Unit also had to work outside the Covid Unit on the day of the elopement [10/30/2022]. The Administrator stated, .I don't think so .the staff had redirected the resident [Resident #5] several times that day and prevented him from getting out. The Administrator confirmed she had not reviewed the staff assignments for 10/30/2022. The Administrator was asked what the root cause analysis was determined for Resident #5's elopement incident during the QAPI meeting on 10/31. The Administrator stated, He [Resident #5] wanted to exit the facility to go see his brother. The root cause analysis for QAPI on 10/21 was staffing due to outbreak [COVID-19] .We were to have some people work the Unit [Covid Unit] designated only to COVID [Unit] unless call ins. During an interview on 11/8/2022 at 4:36 PM, the DON stated, .to be honest with you, we hadn't looked at the staffing .I told the Staffing Coordinator a couple of weeks ago that we need designated staff to staff the Covid Unit only .The DON was asked if the fact that Resident #5 was positive for COVID should not have been considered an incident [of potential COVID-19 exposure]. The DON was asked if the Supervisor should have collected statements when Resident #5 got out of the door. The DON confirmed that Resident #5's exit from the COVID Unit and exit from the facility should have been considered an incident. The DON stated, .I can see where you are coming from . The DON confirmed the Registered Nurse (RN) Supervisor (RN #1) should have gotten statements. (continued on next page)

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	445331	A. Building B. Wing	12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Graceland Rehabilitation and Nursing Care Center	1250 Farrow Road Memphis, TN 38116

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/21/2022 at 3:40 PM, the Chief Operating Officer (COO) stated, .fall investigation should be signed .fall risk assessments should be completed after a fall and on admission .if staff observe a fall and do not report it to the nurse, the staff are educated and disciplined .should be in their personnel record . Interview on 12/2/2022 at 5:20 PM, the Interim DON confirmed there were some issues with the psychiatric referrals that were identified yesterday [12/1/2022]. The DON stated, .We are finding out that the orders are written, but they are not being seen immediately after the order is written .there is a delay in services . The QAPI committee failed to maintain oversight, establish, and implement policies and procedures to ensure adequate staff supervision to protect vulnerable residents from neglect and unsafe elopement episodes. Refer to F600. The QAPI committee failed to maintain oversight, establish and implement policies and procedures to ensure incidents of elopement and neglect were reported to the State Survey Agency. Refer to F609. The QAPI committee failed to maintain oversight, establish, and implement policies and procedures to ensure incidents of elopement were thoroughly investigated. Refer to F-610. The QAPI committee failed to maintain oversight, establish, and implement policies and procedures to ensure elopement incidents were prevented, identified, and thoroughly investigated. Refer to F-689. The facility failed to provide sufficient nursing staff to adequately supervise a vulnerable resident with severe cognition impairment, wandering and elopement behaviors, a positive COVID diagnosis from exiting the COVID Unit 3 different times, and then exited the facility unsupervised and without Personal Protective Equipment (PPE) in place. Refer to F725. The facility failed to ensure licensed nurses had the competencies and skill sets necessary to perform assessments and complete fall risk assessments for residents with impaired safety awareness. According to the investigation, Resident #5, who was positive for COVID-19 exited the COVID Unit barrier 3 times by unzipping the barrier, and then exited the facility unsupervised on 10/30/2022. Resident #5 was found by staff walking on the sidewalk into the parking lot, approximately 223 feet from the facility. Neither Resident #5, nor staff who interacted with him, were using Protective Personal Equipment (PPE), which had the potential to expose staff and other residents to COVID-19. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's failure to ensure staff had the competencies and skill sets necessary to ensure residents having immediate needs for psychiatric services, received such services in a timely manner. This failure resulted in actual harm when Resident #3, a vulnerable resident with diagnoses of Depression, Dementia and COVID-19, sustained a significant weight loss of 7.8 percent (%) in 1 month, after having suicidal ideations and voiced that he wanted to die and would starve himself. Resident #3 was admitted and isolated in the COVID Unit on 8/9/2022. Resident #3 voiced to Social Services and his family of wanting to die and had suicidal ideations on 8/12/2022. Resident #3 refused medications and meals, resulting in significant weight loss in 1 month. The facility was unable to provide documentation for Social Service monitoring or follow-up. The facility's failed to ensure licensed nurses had the competencies and skill sets necessary to perform and complete admission assessments and fall risk assessments on admission for Resident #9 and Resident #2. Refer to F726. The QAPI committee failed to maintain oversight, failed to establish and implement policies and procedures to ensure effective social services to maintain the highest practicable physical, mental, and psychosocial well-being for residents were provided. The facility's QAPI Committee failed to identify the systemic issues of psych services referrals not being processed timely and the social services system failure to include documentation, visits, referrals and meeting the needs of residents with agitation and suicidal threats. Refer to F745. The QAPI Committee failed to maintain oversight, failed to establish and implement policies and procedures, failed to ensure Administration consistently followed policies and procedures, failed to provide oversight of nursing staff, failed to identify the root cause of concerns identified in the facility, and failed to ensure systems and processes were developed and consistently followed by facility staff. Refer to F835. The QAPI committee failed to maintain oversight, establish, and implement policies and procedures to ensure staff maintained appropriate transmission-based precautions for infectious diseases, and failed to ensure staff used proper PPE when caring for residents with known infectious COVID-19. The facility's QAPI Committee failed to identify, investigate, analyze and evaluate the incident of Resident #5 (a COVID positive resident) exiting the COVID Unit multiple times and having the potential to expose other residents and staff when the resident eloped. Refer to F-880. The surveyors verified the Removal through observations, review of audits, meeting minutes, and staff interviews as follows: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. All employees including QAPI team members were in-serviced on 11/11/2022 on how to properly identify residents who were wanderers/exit-seekers and elopement risk along with review on wanderers, exit-seekers and residents at risk for elopement, incidents and accidents, and thorough investigation and reporting. The Administrator/DON/ADON were consulted on 11/17/2022 regarding incidents and accidents, adequate and through investigation and proper reporting to the proper agencies in a timely manner. All employees, including QAPI team members, were in-serviced on 11/11/2022 on who to report to if a resident was identified as going out of the facility unsupervised, and how and when to start an investigation. Administrator/DON/ADON to go over daily staffing the day before with the Staffing Coordinator (SDC), and each morning with the QAPI team members to ensure adequate and competent staff facility-wide, including the COVID Unit, based on acuity and census. Administrator/DON/ADON check staffing daily to ensure there is dedicated staff members on the COVID Unit to reduce the risk of exposure to other residents and staff for COVID 19. Administrator consulted DON/ADON/Social Services on prompt procedure regarding psychiatric referrals and residents being seen by psychiatric services in a timely manner. All non-emergent behavioral referrals and residents being seen by psychiatric services within the week and all emergency cases will be attended by Primary Care Provider (PCP). Psychiatric service providers will be notified via telephone regarding transfers to hospitals. 2. The DON in serviced ADON/SDC and Unit Managers on 12/01/2022 regarding completion of all new admissions, readmissions and any assessments that are warranted per resident change of condition. 3. The facility immediately reviewed policies and procedures with all staff regarding incidents and accidents, thorough investigation and reporting to proper authorities in a timely manner on 11/11/2022. DON/ADON put a monthly calendar in place to ensure that a Manager on Duty is in place including weekends and holidays. In the event that there is any change of condition or occurrences concerning any residents at the facility, it will be thoroughly investigated and reported timely. Administrator/DON/Unit managers review all occurrences, change of condition, and all assessments, including new admissions, readmissions and any assessments warranted by change of condition or occurrences in the morning QAPI meetings. DON/ADON/SW/UM will review all psychiatric referrals in the morning QAPI meetings to ensure all referrals are processed and residents are seen by psychiatric services in a timely manner. Any negative findings will be corrected or completed immediately and brought to the next morning QAPI meeting to ensure completion and accuracy of assessments. The facility's noncompliance of F-867 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility is required to submit a plan of correction.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31839 Based on policy review, medical record review, video surveillance review, observation, and interview the facility failed to maintain Contact Isolation with Droplet Precautions for 1 of 11 (Resident #5) Covid-positive residents reviewed for infection control. Resident #5 exited the COVID-19 isolation unit, attempted to exit the 500 hall door twice, was then placed at a nursing station outside of the COVID Unit by staff; Resident #5 was observed out of the COVID Unit walking on the 700 hall, and on the sidewalk outside the building without personal protective equipment (PPE). Three (3) of 3 staff members, (Certified Nursing Assistant (CNA) #1, Licensed Practical Nurse (LPN) #1 and #2) failed to wear PPE when providing care for Resident #5. The facility failure to contain COVID-19 and prevent exposure potentially affected other residents and staff on the 500 hall, 700 hall, and 800 hall. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator, the Interim Director of Nursing (DON) were notified of the Immediate Jeopardy on 11/22/2022 at 3:57 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-880. The facility was cited at F-880 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy existed from 10/30/2022 through 12/2/2022. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 11/29/2022 at 11:16 AM, and was validated onsite by the surveyors on 11/30/2022 -12/2/2022 through observations, review of audits, meeting minutes, and staff interviews. The findings include: 1. Review of the facility's undated policy titled, Policies and Practices-Infection Control, revealed, .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .2. The objectives of our infection control policies and practices are to .Prevent, detect, investigate, and control infections in the facility . Review of the facility's undated policy titled, COVID-19 Management of Suspected or Confirmed Residents, revealed .Restrict residents with respiratory infections .to their rooms .If they leave the room, resident should be encouraged and assisted to wear a facemask . Review of the facility's undated policy titled DISCONTINUATION OF TRANSMISSION BASED PRECAUTION RELATED TO COVID -19, revealed .all residents tested positive .will be monitored closely to prevent spread of infection related to COVID-19 .PURPOSE: To protect all residents and staff and to keep all residents and staff away from contracting COVID-19 virus . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, .Personal Protective Equipment (PPE), revealed .To ensure that . PPE .is provided for all staff at the facility, including .facemasks, gloves, gowns, and eye protection .when interacting with COVID-19 suspected or confirmed residents .Prior to entering areas where residents are suspected or confirmed with COVID-19 .Education provided to staff on proper usage, procedure . Review of the facility's undated policy titled, .Contact Precautions, revealed .Transmission Based Precautions are designed for residents documented or suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond stand precautions are needed to interrupt transmission . Review of the facility's undated policy titled .Personal Protective Equipment (PPE), revealed .Personnel will be trained on our infection control policies and practices caring for or encountering a COVID+ [positive] or COVID suspected or COVID unknown resident .FACE SHIELD OR GOGGLES .GLOVES .FIT-tested N95 RESPIRATOR .GOWN . 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of Wernicke's Encephalopathy, Altered Mental Status, Alcohol Abuse, Adult Failure to Thrive, Cerebral Infarction, and Cognitive Social or Emotional Deficit following Cerebral Infarction. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #5 had severely impaired cognition for daily decision making. Review of the Care Plan dated 8/16/2022, revealed Resident #5 was at risk for elopement related to anxiety and sadness related to isolation precautions related to COVID-19. Review of a physician's order dated 10/28/2022, revealed Resident #5 had an order for contact isolation with droplet precautions related to a positive COVID test. Review of a Census Report dated 10/28/2022, revealed Resident #5's room was changed to the COVID Unit. Review of the facility's camera footage dated 10/30/2022 at 11:00 AM, revealed 2 staff members, LPN #1 and CNA #1, and Resident #5 standing in the hallway beside an exit door without full PPE. Review of a Progress Note dated 10/30/2022 at 11:33 AM, revealed .exit seeking x [times] 3 left COVID hall x 2 this am .on 700 hall x1 .on 500 hall door x 2 .found in .parking lot . Observation in the COVID Unit located on the 600 Hall on 11/7/2022 at 4:48 PM, revealed the Covid Unit had plastic barriers with zippers to provide Contact and Droplet Precaution isolation for COVID-positive residents. The barriers were located beginning at room [ROOM NUMBER] and ended at room [ROOM NUMBER] and at the exits to the 500 and 700 hall. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/8/2022 at 12:58 PM, Certified Nursing Assistant (CNA) #1 stated, .Resident #5 kept getting out of the COVID Unit .I had to assist to bring him back in .he was unzipping the plastic to go out of the unit, and I found him at the 500 hall exit door twice .I would go get him from the door and bring him back to the unit .once he got out and was found by a nurse walking around on the 700 hall .I don't know which way he got out of the unit that time, because I didn't see him .I did see him unzipping the barrier trying to get out . CNA #1 was asked if Resident #5 should have been out of the COVID Unit. She stated, .No, he should have stayed on the unit, but I couldn't keep my eyes on him. I had other residents . During an interview on 11/18/2022 at 1:04 PM, Licensed Practical Nurse (LPN) #1 stated, I was the nurse on the COVID Unit. He [Resident #5] had gotten out .found him out of the COVID Unit attempting to get out the exit door across from the DON's office on the 500 hall .we would take him back in the unit, and before you knew it, he was out again .we were doing our best to keep him on the unit .I sat him at the desk for a short time just to keep an eye on him .but I could not keep a watch on him. That's when I sat him at the desk, after he had gotten out of the Covid Unit .I probably shouldn't have .but I did . During an interview on 11/21/2022 at 3:00 PM, the Interim DON/Infection Control Preventionist stated, .we had an outbreak of COVID-19 after staff and a large number of residents tested positive on 10/21/22 .we were trying to maintain the unit with designated staff to work only in the COVID unit . She was asked if a COVID-positive resident should be out of the COVID Unit without PPE walking the halls. She stated, . absolutely not .he should have remained isolated . should not be outside of the COVID Unit wandering around in patient areas on different halls . She was asked if a COVID-positive resident should be sitting at the desk with staff outside the COVID Unit. She stated, .no .a COVID-positive resident on COVID isolation precautions should not have been at the nurses' station outside of the Covid Unit .There should have been designated staff in the Covid Unit and not taking care of other residents outside of the Covid Unit. She confirmed staff should be wearing full PPE when caring for a COVID-positive resident in the Covid Unit or in contact with a COVID-positive resident. During a telephone interview on 11/22/2022 at 3:15 PM, LPN #2 stated, .I was sitting at the desk, and I saw him [Resident #5] walking. He did not have a mask on. He was coming from the 700 hall .I gave him a mask and assisted him back to the COVID Unit .I was the nurse on the other side .don't know which way he came from .I knew he was supposed to be on the COVID Unit . Refer to F-689, F-609, F-610, F-726, F-725, F-835 and F-867. The surveyors verified the Allegation of Compliance (AoC) Removal Plan through record review, observations, audit reviews, review of education and sign-in sheets, and interviews for the immediate corrective actions listed below: 1. Resident #5, who was wandering out of Covid Unit, had completed his quarantine period as per facility protocol and discharged from the COVID Unit on 11/9/2022 with no signs and symptoms of COVID-19. Resident #5, who wandered outside the COVID Unit unsupervised was monitored closely for signs and symptoms of COVID and none reported. The surveyors verified on site by interview with the DON and Administrator (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. As of 11/23/2022, the facility had no Covid positive residents residing in the Covid Unit. All residents completed required quarantine period and were discharged out of Covid Unit. No new residents tested positive for Covid-19 and required isolation. This was validated onsite by surveyors through observation and census review. 3. If any residents test positive in the future, the Administrator/DON will review census and clinical acuity and staff accordingly. The Administrator/DON will monitor staffing for the COVID Unit daily to ensure adequate staffing on the COVID Unit. Clinical acuity and the COVID Unit census will be reviewed by the Administrator/Don daily and staffed accordingly as follows: 1-5 residents minimum 1 nurse, 6-10 residents minimum 1 nurse and 1 CNA, 11-20 residents minimum 1 nurse and 2 CNA'S. Nurses/CNAs will ensure that all residents residing on the COVID Unit will follow the facility's protocol on PPE usage. The facility initiated every-30-minute checks on all residents at risk for elopement/wandering. This was validated onsite by surveyors through review of the COVID Unit census with the staffing assignment sheets, observation, and interviews. 4. The facility will ensure that adequate supervision for the residents including wandering residents residing on the COVID Unit are monitored closely by Nurses/CNAs designated to the COVID Unit to reduce the risk of exposure to COVID outside of the COVID Unit. Staff will monitor by every-30-minute checks on all residents at risk for elopement/wandering risk residents. Nursing staff will be in-serviced on additional infection control and transmission-based precautions by staff educator with a completion date of 11/23/2022. This was validated onsite by surveyors through review of COVID Unit census with staffing assignment sheets, review of in-service sign-in sheets, observation, and interviews. 5. The facility will ensure residents with active wandering behaviors residing on the COVID Unit are monitored and transmission-based precautions are maintained to ensure residents and staff are not exposed. Nurses/CNAs will ensure that all residents residing on the COVID Unit will follow the facility's protocol on PPE usage. The Administrator/DON will monitor staffing for the COVID Unit daily to ensure adequate staffing on the COVID Unit to reduce the risk for active wandering residents leaving the COVID Unit unsupervised. This was validated by review of the COVID Unit census with staffing assignment sheets, review of in-service sign-in sheets, observation, and interviews conducted with facility staff, agency staff, DON, Staffing Coordinator and Administrator. The facility's noncompliance of F-880 continues at a scope and severity of E for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction.